MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

0144 — Reg. Dist. No. 00104

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
c. LENGTH OF STAY IN 1b: 1 month
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Brock Bridge Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Alleghany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: Route #2, Wi lliams Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ella — Middle: Mae — Last: Ammons

4. DATE OF DEATH: Month: January — Day: 20, — Year: 19 60

5. SEX: Female

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 10, 1934

9. AGE (In years last birthday): 25 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Matthew Dolly

14. MOTHER'S MAIDEN NAME: Edna Ash

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT — Address: Robert Ammons, husband. Same address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO
434.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Rheumatic fever

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/13, 1960, to 1/20, 1960, that I last saw the deceased alive on 1/13, 1960, and that death occurred at 7:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John R. Buell M.D. — ADDRESS (Street, city or town, state): 402 Main St., Laurel, Md. — DATE SIGNED: 1/20/60

PHYSICIAN'S NAME (Type): John R. Buell M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Jan. 23, 1960
22c. NAME OF CEMETERY OR CREMATORY: Mt. Herman Cemetery
22d. LOCATION (City, town, or county) (State): Allegany County, Mafyland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: John J. Hafer, Cumberland, Maryland

24a. REC'D BY REGISTRAR — DATE: JAN 25 '60

24b. REGISTRAR'S SIGNATURE: Cathy L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0106 CERTIFICATE OF DEATH

Reg. Dist. No. 00105

1. PLACE OF DEATH
a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: A. A. General

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md. — b. COUNTY: A A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 1107 Spa View Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Adam Middle Kahler Last Backer

4. DATE OF DEATH: Month 1 — Day 24 Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct 14th 1893

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supervisor

10b. KIND OF BUSINESS OR INDUSTRY: Balto Gas & Electric Co.

11. BIRTHPLACE (State or foreign country): Baltimore Md

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: John William Backer

14. MOTHER'S MAIDEN NAME: Elizabeth Weaver Kahler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): World War I

16. SOCIAL SECURITY NO.: 212-05-6407

17. INFORMANT: Elisabeth S. Backer — Address: (2)

MEDICAL CERTIFICATION

19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
434.4

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 8, 1958, to JAN 24, 1960, that I last saw the deceased alive on JAN 24 1960, and that death occurred at P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): Annapolis, Md — DATE SIGNED

PHYSICIAN'S NAME (Type): E. Lindsay H. — Annapolis Md — 1/24/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1-27-1960
22c. NAME OF CEMETERY OR CREMATORY: London Park
22d. LOCATION (City, town, or county) (State): Baltimore Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Fayler Sons — ADDRESS: Annapolis Md.

24a. REC'D BY REGISTRAR DATE: JAN 28 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0107 CERTIFICATE OF DEATH

Reg. Dist. No. 00106

1. PLACE OF DEATH
o. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL ond give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporote limits, write RURAL ond give nearest town): X Rural - Gambrills
d. STREET ADDRESS: LuMaRo Trailer Estates
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Daisy — Middle: P — Last: BALDWIN
4. DATE OF DEATH: Month: January — Day: 2 — Year: 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: September 4, 1889
9. AGE (In yeors lost birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): England
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: George Pascal
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 550 32 0662
INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o): CEREBRAL THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 6 DAYS
332x
DUE TO
Conditions, if ony, which gave rise to immediate couse (o), stoting the underlying couse lost.
(b) ARTERIOSCLEROSIS, GEN. — UNKNOWN
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Doy, Yeor 19
20d. INJURY OCCURRED While ot work ☐ Not while ot work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 25, 1959, to Jan. 2, 1960, that I last saw the deceased alive an Jan. 2, 1960, and that death occurred at 3:55 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward S Beck M.D. — ADDRESS (Street, city or town, state): 41 Southgate Ave., Annapolis, Maryland — DATE SIGNED: 1/4/60

PHYSICIAN'S NAME (Type): Edward S. Beck

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal-Burial
22b. DATE THEREOF: Jan. 6, 1960
22c. NAME OF CEMETERY OR CREMATORY:
22d. LOCATION (City, town, or county) (State): Long Beach, Calif.

23. FUNERAL DIRECTOR'S SIGNATURE: Hopping Funeral Home — ADDRESS: Annapolis, Maryland
24a. REC'D BY REGISTRAR DATE: JAN 7 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00107

CERTIFICATE OF DEATH

0145 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 3 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 544 Munroe Circle

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 60 Glen Burnie
d. STREET ADDRESS: 1 544 Munroe Circle
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Beatrice Middle Irene Last Bartels

4. DATE OF DEATH: Month Jan. Day 31, Year 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Mar. 11, 1900

9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles ~~Earl~~ Campbell

14. MOTHER'S MAIDEN NAME: Emma Zellner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: ---

INFORMANT Address: Mrs Harry Guinn, Same as 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August, 19 57 to 1/31/, 1960, that I last saw the deceased alive on 1/27, 19 60, and that death occurred at 9: a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: C.R.MacDonald M.D. M.D.
ADDRESS (Street, city or town, state): 204 Crain Hghy, SW, Glen Burnie
DATE SIGNED: 1-31-60

PHYSICIAN'S NAME (Type): C. R. MacDonald, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/3/60
22c. NAME OF CEMETERY OR CREMATORY: Locust Wood Memorial
22d. LOCATION (City, town, or county) (State): Delaware Twp. New Jersey

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Hopping and Kirkley, Glen Burnie, Md.

24a. REC'D BY REGISTRAR DATE: FEB 2 '60
24b. REGISTRAR'S SIGNATURE: Arthur L Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SB

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

0108

Reg. Dist. No. 00108

1. PLACE OF DEATH
a. COUNTY A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 47 Southgate Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. — b. COUNTY A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis
d. STREET ADDRESS 47 Southgate Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Annie Middle: E. Last: Barton

4. DATE OF DEATH Month: 1 Day: 31 Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Nov 18th 1859

9. AGE (In years last birthday): 100 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Annapolis Md

12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME: William E Brooks

14. MOTHER'S MAIDEN NAME: Susan Mace

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address: Mrs Albert E. Leffler (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio Vascular Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 days
422.2
DUE TO (b) Pulmonary Congestion — 2 Days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) Myocarditis — Many Months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9-24-59, 19__, to 1-31-60, 1960, that I last saw the deceased alive on 1-31-60, 1960, and that death occurred at 11:50 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: J. Oliver Purvis M.D. — ADDRESS (Street, city or town, state): 40 Franklin St. Annapolis Md — DATE SIGNED: 2-1-60

PHYSICIAN'S NAME (Type): J. OLIVER PURVIS.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-3-1960
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemt
22d. LOCATION (City, town, or county) (State): Annapolis Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons — ADDRESS: Annapolis Md

24a. REC'D BY REGISTRAR DATE: 2 4 60

24b. REGISTRAR'S SIGNATURE: Christine L. Hanna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0109 CERTIFICATE OF DEATH

Reg. Dist. No. 00109

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis — c. LENGTH OF STAY IN 1b: D.O.A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural - Edgewater
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel Genera l Hospital	d. STREET ADDRESS: South River Park — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Harry	Leroy	BEALL	January	13	1960

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White		December 25, 1904	55 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter	Building construction	Maryland	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Phillip Beall	Lillie Hardy Beall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
no	no	214 05 0916	Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH minutes

420.1

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/13, 1960, to 1/13, 1960, that I last saw the deceased alive on 1/13, 1960, and that death occurred at 6 50 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard N. Peeler M.D. — ADDRESS (Street, city or town, state): 121 CATHEDRAL ST — DATE SIGNED: 1/13/60

PHYSICIAN'S NAME (Type): RICHARD N. PEELER — ANNAPOLIS, MD

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Jan. 16, 1960	Cedar Bluff Cemetery	Annapolis, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Hopping Funeral Home	Annapolis, Maryland	JAN 18 '60	Arthur S. Evans

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

0146 — Reg. Dist. No. 00110

1. PLACE OF DEATH
a. COUNTY: A. A.
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ferndale
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 19 Eugenia Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Ferndale
d. STREET ADDRESS: 19 Eugenia Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First RUDOLPH Middle Last BERNARD

4. DATE OF DEATH: Month Jan. Day 9, Year 19 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Mar. 14, 1887

9. AGE (In years lost birthday): 72 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Robert Bernard

14. MOTHER'S MAIDEN NAME: Anna. - unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT: Mrs. Lillian I. Bernard - 19 Eugenia Ave.
Address: Ferndale

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertensive Cardio vascular diseases
DUE TO
(b):
DUE TO
(c):

443X

Conditions, if ony, which gove rise to immediate cause (a), stating the underlying cause lost.

INTERVAL BETWEEN ONSET AND DEATH: 4 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Doy, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1955, to January 9, 1960, that I last saw the deceased alive an 1/8 /60, 19, and that death occurred at 2.10 A.M. from the causes and an the date stated above.

ACTUAL SIGNATURE: Gustave H Faubert M.D. — ADDRESS (Street, city or town, state): Glen Burnie, Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): Gustave H. Faubert, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1/12/60

22c. NAME OF CEMETERY OR CREMATORY: Lorraine Park Cem.

22d. LOCATION (City, town, or county) (State): Woodlawn, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Wm. J. Tickner & Sons - Balto 17, Md.
ADDRESS

24a. REC'D BY REGISTRAR DATE: JAN 12 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

0110 Reg. Dist. No. 00111

1. PLACE OF DEATH
a. COUNTY: A. A. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ANNE Arundel Gen.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS 10
d. STREET ADDRESS: 90-College Crk't-Terrace
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

063

3. NAME OF DECEASED (Type or print): First Edward Middle BLACKSTON Last
4. DATE OF DEATH: Month 1 Day 1 Year 1960

5. SEX: M.
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Sept. 18-1879
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Construction
10b. KIND OF BUSINESS OR INDUSTRY: Laborer
11. BIRTHPLACE (State or foreign country): A.A. Co. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Edward BLACKSTON
14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 212-05-3220
17. INFORMANT: A. Edna-Brown-62-College-Crk. Terr Address ANNAPOLIS Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Embolus — INTERVAL BETWEEN ONSET AND DEATH
450.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerosis Generalized (Severe) — 3 days
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 1, 1959 to Jan 1, 1960, that I last saw the deceased alive on Jan 1, 1960, and that death occurred at 9:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R L Richardson M.D. ADDRESS (Street, city or town, state): 110—CLAY STREET DATE SIGNED: 1/4/60
PHYSICIAN'S NAME (Type): R L. Richardson ANNAPOLIS, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 1-5-60
22c. NAME OF CEMETERY OR CREMATORY: Brewer-Hill
22d. LOCATION (City, town, or county) (State): ANNAPOLIS—Md.

23. FUNERAL DIRECTOR'S SIGNATURE: C. E. Hicks III ADDRESS: ANNAPOLIS—Md.
24a. REC'D BY REGISTRAR DATE JAN 8 '60
24b. REGISTRAR'S SIGNATURE: Clinton S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

0111

00112 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A.A. County MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 914 Central Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: A. A. County
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 914 Central Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Richard Middle: H. Last: Boardley
4. DATE OF DEATH: Month: 1 Day: 30 Year: 1960
5. SEX: Male
6. COLOR OR RACE: Col
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 9-20-1874
9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John Boardley
14. MOTHER'S MAIDEN NAME: Francis Lane
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 214-05-1396A
INFORMANT: Helen Rawlings Address: 914 Central St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
434.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Year: Haur a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Nat while at work ☐
20e. PLACE OF INJURY (Hame, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12-[illegible]-[illegible], 19__, to 1-30-60, 19__, that I last saw the deceased alive on 1-[illegible]-60, 19__, and that death occurred at 5:[illegible] M, from the causes and on the date stated above.

ACTUAL SIGNATURE: A. T. Allen M.D. ADDRESS (Street, city or town, state): 62 Cathedral St DATE SIGNED: 2-1-60
PHYSICIAN'S NAME (Type): A T ALLEN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-2-1960
22c. NAME OF CEMETERY OR CREMATORY: Davidsonville
22d. LOCATION (City, town, or county) (State): Davidsonville Md.
23. FUNERAL DIRECTOR'S SIGNATURE: William Reesett ADDRESS: Anna. Md.
24a. REC'D BY REGISTRAR DATE: FEB 3 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Hines

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0112 CERTIFICATE OF DEATH

Reg. Dist. No. 00113

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b: 33 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 ANNAPOLIS
d. STREET ADDRESS: 1 5 Revell Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Eise — Middle: (n) — Last: BROOKS

4. DATE OF DEATH: Month: 1 — Day: 1 — Year: 1960

5. SEX: M

6. COLOR OR RACE: Cauc.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-22-86

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. NAVY

10b. KIND OF BUSINESS OR INDUSTRY: MILITARY

11. BIRTHPLACE (State or foreign country): N.Y.

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Frank BROOKS

14. MOTHER'S MAIDEN NAME: Lillian WILDER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES
(If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO.: ----

17. INFORMANT: Wife: Lillian M. Brooks — Address: 5 Revell Street, Annapolis, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
199.2
DUE TO
(b): Carcinomatosis — 3 Months
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 0800 1 Jan., 1960, to 2030 1 Jan., 1960, that I last saw the deceased alive on 1900 1 Jan., 1960, and that death occurred at 8:30 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: L. Mazzarella M.D. — ADDRESS (Street, city or town, state): U.S. NAVAL HOSPITAL, ANNAPOLIS, MD. — DATE SIGNED

PHYSICIAN'S NAME (Type): I. MAZZARELLA LT MC USNR — U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: January 4, 1960
22c. NAME OF CEMETERY OR CREMATORY: Annapolis National Cemet.
22d. LOCATION (City, town, or county) (State): Annapolis, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: HOPING FUNERAL HOME 172 West St., — ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: JAN 5 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physicion.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar priar to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00114

0147 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 13yrs. 3mo. 1day

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3Vol-4
d. STREET ADDRESS: 2434 Etting Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

510

3. NAME OF DECEASED (Type or print): First: Adelaide — Middle: — Last: Brown

4. DATE OF DEATH: Month: 1 — Day: 10 — Year: 1960

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 8/10/97

9. AGE (In years last birthday): 62 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James Harvey

14. MOTHER'S MAIDEN NAME: Priscilla

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT — Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH

434.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Schizophrenic Reaction, Paranoid Type

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): ----------

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year: ----------19--

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — **20f.** (City or town) (County) (State)

21. **I certify** that I attended the deceased from 10/9, 1946, to 1/10, 1960, that I last saw the deceased alive on 1/10, 1960, and that death occurred at 9:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Hildegarde Heard Reisman M.D. — ADDRESS (Street, city or town, state): Crownsville State Hospital, Md. — DATE SIGNED: 1/11/60

PHYSICIAN'S NAME (Type): Hildegard Heard Reisman, M. D. — Crownsville State Hospital, Md. — 1/11/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: 1-13-60

22c. NAME OF CEMETERY OR CREMATORY: Mt. Auburn

22d. LOCATION (City, town, or county) (State): Baltimore Md.

23. FUNERAL DIRECTOR'S SIGNATURE: George G. Kelson — ADDRESS: 1345 N. Calhoun St.

24a. REC'D BY REGISTRAR DATE: 1-15-60 JAN 20 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Kemp

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G255 1/27/60 iwk

CERTIFICATE OF DEATH

0148

00115

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A. A. County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: A. A. County
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Edgewater Md.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Benjamin — Middle: Brown — Last: Sr.

4. DATE OF DEATH: Month: 1 — Day: 19 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: Col

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-25-1894

9. AGE (In years last birthday): 65 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Benjamin Brown

14. MOTHER'S MAIDEN NAME: Mary Elizabeth Duvall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 579-44-0769

INFORMANT: Benjamin Brown — Address: Edgewater Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): ARTERIOSCLEROTIC HEART DISEASE — INTERVAL BETWEEN ONSET AND DEATH: 2 YRS.

420.0

DUE TO (b):

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): PERIPHERAL ARTERIOSCLEROSIS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-15, 1960, to 1-19, 1960 that I last saw the deceased alive on 1-13, 1960, and that death occurred at 9:00 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward L Burk M.D. — ADDRESS (Street, city or town, state): 4 Smithgate Lane, Annapolis, Md. — DATE SIGNED: 1/19/60

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 1-24-1960 — 22c. NAME OF CEMETERY OR CREMATORY: Hope Chapel — 22d. LOCATION (City, town, or county) (State): A. A. County Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Reese — ADDRESS: Annap. Md.

24a. REC'D BY REGISTRAR DATE: JAN 20 '60 — 24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

0113

Reg. Dist. No. 00116

1. PLACE OF DEATH
a. COUNTY: A A
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 145 Prince George St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 145 Prince Geo St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Catherine Middle: E. Last: Brown

4. DATE OF DEATH: Month: 1 Day: 30 Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec 21-1874

9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Baltimore Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Neiman

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Travis L. Brown Address (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 3 wks.
331X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year / Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-30, 1960, to 1-30, 1960, that I last saw the deceased alive on —, 19—, and that death occurred at 2 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank M Shipley M.D. ADDRESS (Street, city or town, state): 121 Cathedral St DATE SIGNED: 2-1-60

PHYSICIAN'S NAME (Type): Frank M Shipley Annapolis

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-2-1960

22c. NAME OF CEMETERY OR CREMATORY: Cedar Bluff

22d. LOCATION (City, town, or county) (State): Annapolis Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Sayler Sons ADDRESS: Annapolis Md

24a. REC'D BY REGISTRAR DATE: FEB 4 '60

24b. REGISTRAR'S SIGNATURE: Charles L. Travis

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0114

CERTIFICATE OF DEATH

00117

Reg. Dist. No.

M

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Anne Arundel General Hospital

063

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 108 Conduit St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: W — Last: BURRIS

4. DATE OF DEATH: Month: January — Day: 9 — Year: 1960

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: June 30, 1883
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY: TRUCK
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: EDWARD BURRIS
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.:
INFORMANT: MRS RALPH BRADY — Address: (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial failure
DUE TO (b): Chronic arteriosclerotic Heart disease
DUE TO (c): Chronic nephritis

592X

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Doy, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

0

21. I certify that I attended the deceased from Jan 8, 1960, to Jan 9, 1960, that I last saw the deceased alive on Jan 8, 1960, and that death occurred at 11:55 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Emily H. Wilson, M.D. — ADDRESS (Street, city or town, state): Lothian, Md. — DATE SIGNED: 1-11-60

1

PHYSICIAN'S NAME (Type): Emily H. Wilson — Lothian, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1-12-1960
22c. NAME OF CEMETERY OR CREMATORY: Bethel Cemit
22d. LOCATION (City, town, or county): Oak Grove (State): Del.

23. FUNERAL DIRECTOR'S SIGNATURE: John W. Taylor Sons — ADDRESS: Annapolis Md
24a. REC'D BY REGISTRAR DATE: JAN 14 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00118

CERTIFICATE OF DEATH

0115

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL OR INSTITUTION: 110 CHESAPEAKE AVE

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: A. A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
d. STREET ADDRESS: 110 CHESAPEAKE AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: T. — Last: CHURCHILL

4. DATE OF DEATH: Month: — Day: 22 — Year: 1960

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 1st 1879

9. AGE (In years last birthday): 80 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PAINTER

10b. KIND OF BUSINESS OR INDUSTRY: OWN CONTRACTOR

11. BIRTHPLACE (State or foreign country): Annapolis Md

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William Churchill

14. MOTHER'S MAIDEN NAME: Sarah E James

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Grace V. Churchill — Address: (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized Metastasis
177X
DUE TO
(b): Cancer of prostate
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 12, 1959, to Jan 22, 1960, that I last saw the deceased alive on Dec. 15, 1959, and that death occurred at 1.05 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Maurice Klawans M.D. — ADDRESS (Street, city or town, state): 31 South St Balto — DATE SIGNED: 1/22/60

PHYSICIAN'S NAME (Type): MAURICE F. KLAWANS — Annapolis Md

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 1-25-1960

22c. NAME OF CEMETERY OR CREMATORY: CEDAR BLUFF

22d. LOCATION (City, town, or county): ANNAPOLIS (State): MD.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor & Son — ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: JAN 25 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

0116

Reg. Dist. No. 00119

1. PLACE OF DEATH
a. COUNTY: A. A. County MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 100 Lewis Drive

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: A. A. County
c. CITY OR TOWN (If outside corporate limits; write RURAL and give nearest town): Annapolis 10
d. STREET ADDRESS: 100 Lewis Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First George Middle E. Last Coates

4. DATE OF DEATH: Month 1 Day 25 Year 1960

5. SEX: Male
6. COLOR OR RACE: Col
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-10-1900
9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Navy
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Coates
14. MOTHER'S MAIDEN NAME: Mamie Adams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): W.W.I (If yes, give war or dates of service): Navy
16. SOCIAL SECURITY NO.
INFORMANT: Sarah Coates Address: 100 Lewis Drive

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of the Bladder
DUE TO (b): and left Ureter
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
181.8
INTERVAL BETWEEN ONSET AND DEATH: 2 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 6, 1959 to Jan 25, 1960 that I last saw the deceased alive on Jan 25, 1960 and that death occurred at 9:30 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: R. R. Richardson M.D.
ADDRESS (Street, city or town, state): 110 Day Street Annapolis Md.
DATE SIGNED: 1/26/60
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1-28-1960
22c. NAME OF CEMETERY OR CREMATORY: Brewer Hill
22d. LOCATION (City, town, or county) (State): Annapolis Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Reesett ADDRESS: Anna. Md.
24a. REC'D BY REGISTRAR DATE: JAN 27 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kramer

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58B

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

0117

Reg. Dist. No. 00120

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS, MD
c. LENGTH OF STAY IN 1b: 30yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ANNE ARUNDEL GEN. HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD
b. COUNTY: A. A. CO.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 ANNAPOLIS
d. STREET ADDRESS: 1312 WEST ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

063

3. NAME OF DECEASED (Type or print): First JOSEPH Middle G Last COHEN

4. DATE OF DEATH: Month JAN. Day 15, Year 1960

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: APRIL 22, 1890

9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ASST. MGR.

10b. KIND OF BUSINESS OR INDUSTRY: CONVALESCENT HOME

11. BIRTHPLACE (State or foreign country): WASHINGTON, DC

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: NATHAN COHEN

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-16-8842

17. INFORMANT: ROBERT COHEN Address: 220 S. CHERRY GROVE

I

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bc. Pneumonitis, at. trial. — INTERVAL BETWEEN ONSET AND DEATH: 5 days.
492 X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chr. Emphysema - Aplastic Anaemia or Aleukaemic Leukemia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/11, 1960, to 1/15, 1960, that I last saw the deceased alive on 1/15, 1960, and that death occurred at 1130 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Maurice F. Klawans M.D. ADDRESS (Street, city or town, state): 31 Southgate Av. DATE SIGNED: 1/15/60

PHYSICIAN'S NAME (Type): MAURICE F. KLAWANS, Annapolis, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: JAN. 17, 60

22c. NAME OF CEMETERY OR CREMATORY: MISHKON ISRAEL

22d. LOCATION (City, town, or county) (State): BALTIMORE, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Hospital Funeral Home ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: JAN 20 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SS

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

0118

00121 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 14 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 152 Jefferson St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Helen — Middle Elizabeth — Last COMO

4. DATE OF DEATH: Month January — Day 27 — Year 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: November 6, 1958

9. AGE (In years last birthday): 1 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Carl Edward COMO

14. MOTHER'S MAIDEN NAME: Patricia Ann TUCKER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: Hospital records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Vomiting and Diarrhea with dehydration — INTERVAL BETWEEN ONSET AND DEATH: 2 days
481 X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Influenza like illness — 4 days
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/23, 1960, to 1/27/60, 19____, that I last saw the deceased alive on 1/27/60, 19____, and that death occurred at 1:25P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Philip Briscoe M.D.
ADDRESS (Street, city or town, state): 95 Cathedral Street Annapolis
DATE SIGNED: 1/27/60

PHYSICIAN'S NAME (Type): Philip Briscoe — 95 Cathedral St., Annapolis, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1-30-1960
22c. NAME OF CEMETERY OR CREMATORY: Cedar Bluff
22d. LOCATION (City, town, or county) (State): Annapolis Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons — ADDRESS: Annapolis Md

24a. REC'D BY REGISTRAR DATE: FEB 2 '60

24b. REGISTRAR'S SIGNATURE: Corinne S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

0149 Reg. Dist. No. 00122

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 11mo. 22 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: ~~Baltimore~~
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3V01-4
d. STREET ADDRESS: 401 Oxford Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Emma; Middle: ; Last: Conway

4. DATE OF DEATH: Month: 1; Day: 25; Year: 1960

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: December 28, 1886

9. AGE (In years last birthday): 73 yrs.

IF UNDER 1 YEAR: Months; Days — IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Butler

14. MOTHER'S MAIDEN NAME: Alice Larkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unknown

INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Anemia
DUE TO (b): Chronic Lymphatic Leukemia — INTERVAL BETWEEN ONSET AND DEATH: 1 year
DUE TO (c):

204.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/3, 1959, to 1/25, 1960, that I last saw the deceased alive on 1/25, 1960, and that death occurred at 5:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp M.D. — ADDRESS (Street, city or town, state): Crownsville State Hospital, Md. — DATE SIGNED: 1/25/60

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D. — Crownsville State Hospital, Md. — 1/25/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-2-60

22c. NAME OF CEMETERY OR CREMATORY: Crownsville State Hosp.

22d. LOCATION (City, town, or county) (State): Crownsville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Charles Alexander Hyde — ADDRESS:

24a. REC'D BY REGISTRAR DATE: FEB 2 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kimes

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00123

1. PLACE OF DEATH
a. COUNTY A.A.Co. 0119 MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis-MD.
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Anne Arundel General. 099

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD b. COUNTY Balt.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore RE 20 MD 0354.2
d. STREET ADDRESS 1402 3rd Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First William Middle Alvin Last Crosby
4. DATE OF DEATH: Month 1 Day 13 Year 1960
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 12-15-03
9. AGE (In years last birthday) 56 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mgr. Seatfest.
10b. KIND OF BUSINESS OR INDUSTRY Dairy
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John A. Crosby
14. MOTHER'S MAIDEN NAME Henrietta Harrison
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. 215-10-3904
17. INFORMANT Edgar Crosby Address Friendship Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH Sudden
DUE TO (b) 420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE E. Linhardt M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type) E. Linhardt. DATE SIGNED 1/13/60

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 1-16-60
22c. NAME OF CEMETERY OR CREMATORY Friendship
22d. LOCATION (City, town, or county) (State) Anne Arundel Md.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hutchins Funeral Home, Owings Md.
24a. REC'D BY REGISTRAR DATE JAN 18 '60
24b. REGISTRAR'S SIGNATURE Collins & K...

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0120 CERTIFICATE OF DEATH

Reg. Dist. No. 00124

1

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): Annapolis
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in haspital, give street address) OR INSTITUTION: Anne Arundel General Hospita l

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): X RURAL Churchton
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

063

3. NAME OF DECEASED (Type or print): First MARY Middle CATHERINE Last DAWSON

4. DATE OF DEATH: Month January Day 19 Year 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 1, 1888

9. AGE (In years lost birthday): 71 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind af work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: JOHN MULROY

14. MOTHER'S MAIDEN NAME: MARY AGNES McEVOY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT — Address

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Severe secondary anemia — INTERVAL BETWEEN ONSET AND DEATH: ???

578 x

DUE TO

Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse lost.

(b) Massive hemorrhage from lower bowel — ???

DUE TO

Cause undetermined

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 19, 1960, to Jan. 19, 1960 that I last saw the deceased alive on Jan. 19, 1960, and that death accurred at 11:45P M, fram the causes and an the date stated abave.

ACTUAL SIGNATURE: Maurice Klawans M.D. — ADDRESS (Street, city or town, state): 31 Smith Gate Rd Annapolis Md — DATE SIGNED: 1/20/60

PHYSICIAN'S NAME (Type): Maurice Klawans

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1/22/60

22c. NAME OF CEMETERY OR CREMATORY: Woodfield

22d. LOCATION (City, town, or county) (State): Galesville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Bernard O. Hardesty — ADDRESS: Galesville, Md

24a. REC'D BY REGISTRAR DATE: JAN 25 '60

24b. REGISTRAR'S SIGNATURE: Evelina L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires thot the death certificate be executed within 24 hours after death. Page 4 may be retained by the haspital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00125

CERTIFICATE OF DEATH

0150 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severn
c. LENGTH OF STAY IN 1b: 58 yrs.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Camp Meade Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severn
d. STREET ADDRESS: Camp Meade Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ISAIAH — Middle - — Last DURNER

4. DATE OF DEATH: Month JANUARY — Day 15, — Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 23 July 1873

9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Watchman (ret.)

10b. KIND OF BUSINESS OR INDUSTRY: John Geiss

11. BIRTHPLACE (State or foreign country): Severn, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: (Unknown) Durner

14. MOTHER'S MAIDEN NAME: (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): ////////////

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT: Mrs. Lyndall Warfield, Address: Same As #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Infarct — INTERVAL BETWEEN ONSET AND DEATH: 10 days

422.1

DUE TO (b): Generalized Arteriosclerosis — 2 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Cardio Vascular Disease — 2 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): fracture Right hip

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year, Hour o. m. p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or Town) (County) (State)

21. I certify that I attended the deceased from Dec 28 1959 to Jan 15 1960 that I last saw the deceased alive on Jan 13 1960, and that death occurred at 5 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE, M.D.: Joseph Lipsky — ADDRESS (Street, city or town, state): Odenton Md — DATE SIGNED: 1/15/60

PHYSICIAN'S NAME (Type): JOSEPH LIPSKEY.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 18 January 1960

22c. NAME OF CEMETERY OR CREMATORY: Friendship

22d. LOCATION (City, town, or county) (State): A.A.Co. Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: R. V. Singleton — ADDRESS: Glen Burnie, Md

24a. REC'D BY REGISTRAR DATE: JAN 18 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00126

CERTIFICATE OF DEATH

0151 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural- Pasadena, Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Rt. 3, Box 122, Green Haven, Pasadena, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rt. 3, Pasadena, Md.
d. STREET ADDRESS: Rt. 3, Box 122, Green Haven, Pasadena, Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Pauline — Middle Theresa — Last Ernst

4. DATE OF DEATH: Month January — Day 18 — Year 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 11/27/1918
9. AGE (In years last birthday): 41 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Factory
10b. KIND OF BUSINESS OR INDUSTRY: Factory
11. BIRTHPLACE (State or foreign country): Baltimore, city, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Ernst
14. MOTHER'S MAIDEN NAME: Berger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 217-09-8365
INFORMANT: Mary Helmstetter — Address: Ft. Smallwood Rd. Pasadena, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of the breast — INTERVAL BETWEEN ONSET AND DEATH: 4 years
170X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Metastatic carcinoma — 4 years
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 10, 1957, to Jan. 18, 1960 that I last saw the deceased alive on Jan. 17, 1960 and that death occurred at 3 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: R. M. McLaughlin M.D. — ADDRESS (Street, city or town, state): RFD 8 Box 442 Pasadena, Md. — DATE SIGNED: Jan. 18, 1960

PHYSICIAN'S NAME (Type): R. M. McLaughlin

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 21 Jan. 1960
22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Cem
22d. LOCATION (City, town, or county) (State): Glen Burnie, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: R. V. Singleton — ADDRESS: Glen Burnie, Md.
24a. REC'D BY REGISTRAR — DATE: JAN 20 '60
24b. REGISTRAR'S SIGNATURE: Carlton L. Hines

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00127

CERTIFICATE OF DEATH

0121 Reg. Dist. No.

1. PLACE OF DEATH
o. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 4 hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural - Edgewater
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

063

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	Robert	Lee	ESTEP		January	10	1960

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White		January 10, 1960				4	30

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Newborn		Maryland	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Oden McClain ESTEP	Margaret Agnes SMITH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	INFORMANT Address
		Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 776X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c): Prematurity

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from Jan. 10, 1960, to Jan. 10, 1960 that I last saw the deceased alive on Jan. 10, 1960, and that death occurred at 5:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Clayton Norton M.D. — ADDRESS (Street, city or town, state): Medical Building — DATE SIGNED:

PHYSICIAN'S NAME (Type): Clayton Norton — Severna Park, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	1/11/60	Woodfield	Gaithersburg Md

23. FUNERAL DIRECTOR'S SIGNATURE: Bernard Hardesty — ADDRESS: Gaithersburg Md

24a. REC'D BY REGISTRAR DATE: JAN 14 '60

24b. REGISTRAR'S SIGNATURE: Clifton S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

2063254XVI

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00128
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY ANNE ARUNDEL 0122 MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ~~SHADYSIDE~~
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): U.S. NAVAL HOSPITAL, ANNAPOLIS, MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X (IDLEWILDE) SHADYSIDE
d. STREET ADDRESS: FREDERICK & WINTERS AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First PEGGY Middle JACQUELINE Last EVANS
4. DATE OF DEATH: Month 1 Day 29 Year 1960
5. SEX: Female
6. COLOR OR RACE: ~~WHITE~~ Hazel-
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-10-29
9. AGE (In years last birthday) ~~30~~ 31 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~Housewife~~ SECRETARY
10b. KIND OF BUSINESS OR INDUSTRY: ~~Own Home~~ PAGE ~~ELECTRONIC ENGINEERS~~
11. BIRTHPLACE (State or foreign country): Georgia
12. CITIZEN OF WHAT COUNTRY? ~~USA~~ USA
13. FATHER'S NAME: CECIL WHALEY
14. MOTHER'S MAIDEN NAME: MABEL THRAILKILL
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: UNKNOWN
17. INFORMANT: HUSBAND. FRED EVANS, Address FREDERICK & WINTERS AVE., IDLEWILDE, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) MULTIPLE HEAD INJURIES — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
825X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): (AUTO ACCIDENT)
20c. TIME OF INJURY Month, Day, Year: Hour o. m. p. m. 0925 1-29-60
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Car accidnet
20f. (City or town) (County) (State): Shadyside, Anne Arundel, Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE [signature] M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type) E. L. [illegible] DATE SIGNED 1-30-60

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: FEB. 2, 1960
22c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NATIONAL CEMETERY
22d. LOCATION (City, town, or county) (State): ARLINGTON COUNTY, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: WARNER E. PUMPHREY, INC. ADDRESS: SILVER SPRING, MD. Raymond A. Zeska
24a. REC'D BY REGISTRAR DATE: FEB 3 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0152 **CERTIFICATE OF DEATH** 00129

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 6yrs. 13 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimpre 3V01-4
d. STREET ADDRESS: 923 Sharp Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Austin — Middle — Last Farmer

4. DATE OF DEATH: Month 1 — Day 30 — Year 19 60

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1889

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Carter Palmer

14. MOTHER'S MAIDEN NAME: Meholey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 705-10-7124

17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH:
304x
DUE TO
(b): Chronic Brain Syndrome with Senile Brain Disease
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/17, 19 54, to 1/30, 19 60, that I last saw the deceased alive on 1/30, 19 60, and that death occurred at 6:55 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Hildegard Heard Reiss M.D. — ADDRESS (Street, city or town, state): Crownsville State Hospital, Md. — DATE SIGNED: 2/1/60

PHYSICIAN'S NAME (Type): Hildegard Heard Reissman, M. D. — Crownsville State Hospital, Md. — 2/1/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: 2-2-60

22c. NAME OF CEMETERY OR CREMATORY: Md University

22d. LOCATION (City, town, or county) (State): Baltimore Md

23. FUNERAL DIRECTOR'S SIGNATURE: Wm Reese — ADDRESS: Annapolis Md

24a. REC'D BY REGISTRAR DATE: FEB 3 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 12,13 FilmG255 2-5-60 et

00130

CERTIFICATE OF DEATH

0123

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 81 West St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SANTO — Middle — Last FAZIO

4. DATE OF DEATH: Month January — Day 28 — Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1890

9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber

10b. KIND OF BUSINESS OR INDUSTRY: Barber

11. BIRTHPLACE (State or foreign country): Italy

12. CITIZEN OF WHAT COUNTRY? Italy

13. FATHER'S NAME: Pasquale Fazio

14. MOTHER'S MAIDEN NAME: —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

INFORMANT: Mrs. Josephine Squilace — Address: 2001 Eagle St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia
DUE TO (b): Cirrhosis of Liver
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 8 days

581.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

Late Latent Syphilis

028.1

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 20 1960, to January 28, 1960, that I last saw the deceased alive on January 28, 1960, and that death occurred at 8:25 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: R L Richardson M.D. — ADDRESS (Street, city or town, state): 110 Clay St., Annapolis, Md. — DATE SIGNED: 1/28/60

PHYSICIAN'S NAME (Type): R. L. Richardson

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb. 1, 1960
22c. NAME OF CEMETERY OR CREMATORY: New Cathedral Cem
22d. LOCATION (City, town, or county) (State): 4300 Old Frederick Balto. Md

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Thomas J. Kenny, Inc. 1600 Hollins St.

24a. REC'D BY REGISTRAR DATE: FEB 1 '60

24b. REGISTRAR'S SIGNATURE: Catherine S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

0153 Reg. Dist. No. 00131

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 9mo. 1 year 28 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3V01-4
d. STREET ADDRESS: 2637 Lauretta Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Rose — Middle Anna — Last Fleming

4. DATE OF DEATH: Month 1 — Day 22 — Year 1960

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: January 13, 1902

9. AGE (In years last birthday): 58 yrs.

IF UNDER 1 YEAR / IF UNDER 24 HRS.: Months — Days — Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Un Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Canning Factory

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Pampie Gary

14. MOTHER'S MAIDEN NAME: Mattie Booker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unknown (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-22-1645

17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerotic Cardiovascular Disease with Hypertension

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Old cerebral hemorrhage

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month — Day — Year 19 —

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (City or town) — (County) — (State)

21. I certify that I attended the deceased from 3/24, 19 58, to 1/22, 19 60, that I last saw the deceased alive on 1/22, 1960, and that death occurred at 2:35P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Hildegard Heard Reiss M.D. — ADDRESS (Street, city or town, state): Crownsville State Hospital, Md. — DATE SIGNED: 1/22/60

PHYSICIAN'S NAME (Type): Hildegard Heard Reissman, M. D. — Crownsville State Hospital, Md. — 1/22/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1-26-60

22c. NAME OF CEMETERY OR CREMATORY: Aebutas Mem. Pk.

22d. LOCATION (City, town, or county) (State): Balt., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Charles B. Lewis — ADDRESS: 1634 N. Broadway Balt. 13, Md.

24a. REC'D BY REGISTRAR DATE: JAN 25 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00132

CERTIFICATE OF DEATH

0124 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 208 Lockwood St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert — Middle: THOMAS — Last: FORD

4. DATE OF DEATH: Month: January — Day: 11 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 27, 1892

9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY: Boat Building

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Charles Henry Ford

14. MOTHER'S MAIDEN NAME: Mary Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WWI

16. SOCIAL SECURITY NO.:

INFORMANT: Amy R. Ford — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ARTERIOSCLEROTIC CARDIO-VASCULAR DIS. — INTERVAL BETWEEN ONSET AND DEATH: 10 YRS.
422.1
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): DIABETES MELLITUS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 3, 1960, to 11 JAN, 1960 that I last saw the deceased alive on 10 JAN, 1960, and that death occurred at 9:10 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward S Beck M.D. — ADDRESS (Street, city or town, state): 41 Southgate Ave., Annapolis, Maryland — DATE SIGNED

PHYSICIAN'S NAME (Type): Edward S. Beck

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1-14-1960
22c. NAME OF CEMETERY OR CREMATORY: Cedar Bluff
22d. LOCATION (City, town, or county) (State): Annapolis Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John M Taylor & Sons — ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: JAN 14 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

0154 — Reg. Dist. No. 00133

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel, Md.
c. LENGTH OF STAY IN 1b: 2 yr. 8 mo.
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION): District Training School, Children's Center

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C. 47x-3
d. STREET ADDRESS: 211 F Street N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Allan	James	Gatta	January	25	1960

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
male	white		10/6/48	11 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): --
10b. KIND OF BUSINESS OR INDUSTRY: --
11. BIRTHPLACE (State or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert George Peddler
14. MOTHER'S MAIDEN NAME: Dorothy Josephine Gatta

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): --
(If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: --
17. INFORMANT — Address: Social Service, Children's Center, Laurel, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia
DUE TO
(b): Cerebral Palsy – idiot level
DUE TO
(c): Convulsive Disorder

351x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour / Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
Hour o. m. p. m. 19			

21. I certify that I attended the deceased from June 7, 1957 to Jan. 25, 1960, that I last saw the deceased alive on Jan. 25, 1960, and that death occurred at 2:45p. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James E. Boyland M.D.
ADDRESS (Street, city or town, state): Children's Center, Laurel, Md.
DATE SIGNED: 1/26/60

PHYSICIAN'S NAME (Type): James E. Boyland M.D.
Children's Center, Laurel, Md. 1/26/60

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	1/29/60	Mt Olivet	Washington D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers & Son
ADDRESS: Riverdale Md.
24a. REC'D BY REGISTRAR DATE: JAN 29 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

0155 Reg. Dist. No. 00134

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gambrills c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Gambrills
d. STREET ADDRESS Box 574
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First Eliza Middle Ellen Last Greenleaf
4. DATE OF DEATH Month January Day 15 Year 1960

5. SEX Fem
6. COLOR OR RACE C
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 1-5-1897
9. AGE (In years last birthday) 63 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Joseph Carr
14. MOTHER'S MAIDEN NAME Sarah Boston

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address Martha Jenkins Gambrills Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: Months
156.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Carcinoma Liver —
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from September 19 59 to this death 19 — ; that I last saw the deceased alive on 1-15 19 60, and that death occurred at — P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE Febus Greenberg M.D. ADDRESS (Street, city or town, state) P. O. Box 37 DATE SIGNED 1-15-60
PHYSICIAN'S NAME (Type) Febus Greenberg Odenton Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 1-19-1960
22c. NAME OF CEMETERY OR CREMATORY Wilson Memorial
22d. LOCATION (City, town, or county) Mt. Lubor (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE William Reese ADDRESS Laurel Md.
24a. REC'D BY REGISTRAR DATE JAN 19 60
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

0125 Reg. Dist. No. 00135

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Pasadena - Rural
d. STREET ADDRESS: 9th St. Box-506, Rt-3.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Frank Middle Paul Last GRIFFIN
4. DATE OF DEATH: Month January Day 27 Year 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 12, ~~1900~~ 1899
9. AGE (In years last birthday): 60 ~~59~~ yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Worker
10b. KIND OF BUSINESS OR INDUSTRY: A & O Cattle
11. BIRTHPLACE (State or foreign country): Connecticut Hartford
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George F. Griffin
14. MOTHER'S MAIDEN NAME: Mary Mikiel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) / (If yes, give war or dates of service) /
16. SOCIAL SECURITY NO. 216-01-3513
17. INFORMANT: Adrienne E. Griffin — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Embolism — INTERVAL BETWEEN ONSET AND DEATH: 3 Min.
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Myocardial infarction, post. — " (?)
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year / Hour o. m. p. m. / 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-26-, 1960, to 1-27, 1960, that I last saw the deceased alive on 1-27-60 19, and that death occurred at 3:15 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank M. Shipley M.D.
ADDRESS (Street, city or town, state): 121 Cathedral St., Annapolis, Md.
DATE SIGNED: 1/27/60
PHYSICIAN'S NAME (Type): Frank M. Shipley

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Jan 30-60
22c. NAME OF CEMETERY OR CREMATORY: Holy Cross Cemetery
22d. LOCATION (City, town, or county) (State): Riverdale Prince Georges Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edward A Tomie
ADDRESS: Glen Burnie Md
24a. REC'D BY REGISTRAR DATE: JAN 29 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0156 Item 7 Film 255 2-1-60 el 00136

1. PLACE OF DEATH
a. COUNTY: ~~Baltimore~~ Anne Arundel Co. MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Brooklyn Park
c. LENGTH OF STAY IN 1b: Yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 5802 Redman Street

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: ~~Baltimore~~ Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 50 Baltimore (Brooklyn Pk.)
d. STREET ADDRESS: 5802 Redman Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First ANNA Middle L. Last GULICK

4. DATE OF DEATH: Month January Day 25 Year 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug. 16, 1882

9. AGE (In years last birthday): 77 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): W. Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Vincent Topper

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Family Address: Same

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction
420.1
DUE TO (b): Coronary Occlusion.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Partial

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: William V. Lovitt, Jr. M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): William V. Lovitt, Jr., M.D.

Address (Street, city, town, or county):

DATE SIGNED: 1/26/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1/30/60

22c. NAME OF CEMETERY OR CREMATORY: Ebineezer Cem.

22d. LOCATION (City, town, or country) (State): Romney W.Va.

23. FUNERAL DIRECTOR ADDRESS: McCully Funeral Homes 130 E. Fort Ave. # 30

24a. REC'D BY REGISTRAR DATE: JAN 28 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00137

.0157

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY AA MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn PK
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 321 Hanover PK Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD b. COUNTY aa
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 50 Brooklyn
d. STREET ADDRESS 321 Hanover Park Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Brian Middle A. Lost Hammel.
4. DATE OF DEATH Month 1 Day 29 Year 1960

5. SEX M
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 12-3-59
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR Months Days 8 weeks Hours Min.
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) MD, Baltimore City
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Geo J. Hammel
14. MOTHER'S MAIDEN NAME Jean Ogle Edie 59-35497

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT Family Same Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Upper Respiratory Infection — INTERVAL BETWEEN ONSET AND DEATH 8 days.
475 X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 11, 1959, to Jan 26, 1960, that I last saw the deceased alive on Jan 26, 1960, and that death occurred at ____M, from the causes and on the date stated above.

ACTUAL SIGNATURE P. J. Grimaldi M.D. ADDRESS (Street, city or town, state) 4609 Gov. Ritchie Hway Balto Md DATE SIGNED 1-29-60
PHYSICIAN'S NAME (Type) P. J. GRIMALDI

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 1-30-60
22c. NAME OF CEMETERY OR CREMATORY Glen Haven
22d. LOCATION (City, town, or county) (State) Glen Burnie Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS McCully Funeral Home 130 C Street
24a. REC'D BY REGISTRAR DATE FEB 1 '60
24b. REGISTRAR'S SIGNATURE Arthur S. Kruns

2047263 XV6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00138

0158

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural. Pasadena, md
c. LENGTH OF STAY IN 1b: 1 year
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Bayside Beach
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Pasadena. Md.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Charles Middle Benjamin Last Hardesty

4. DATE OF DEATH: Month January Day 20 Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: November 5, 1880

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Railroad Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Benjamin C. Hardesty

14. MOTHER'S MAIDEN NAME: Elizabeth Cox

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 205-05-7807

INFORMANT: MRS. Carrie Hardesty — Address: Pasadena, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of the lung — INTERVAL BETWEEN ONSET AND DEATH: 1 year
DUE TO
163X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): none

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 15, 1959, to Jan. 20, 1960 that I last saw the deceased alive on Jan. 19, 1960, and that death occurred at 4:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R. M. McLaughlin M.D. — ADDRESS (Street, city or town, state): RFD 8 Box 442 Pasadena Md — DATE SIGNED: Jan 20 1960

PHYSICIAN'S NAME (Type): R. M. McLaughlin

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 23 Jan '60

22c. NAME OF CEMETERY OR CREMATORY: Woodlawn

22d. LOCATION (City, town, or county) (State): Woodlawn, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: R. V. Leighton — ADDRESS: Glen Burnie Md.

24a. REC'D BY REGISTRAR DATE: JAN 22 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kruna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00139

0126 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 12 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X RURAL - Lothian
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

063

3. NAME OF DECEASED (Type or print): First: Julius — Middle: WALTER — Last: HARDESTY

4. DATE OF DEATH: Month: January — Day: 20 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 9, 1877

9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY: RETIRED

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: JAMES DANIEL HARDESTY

14. MOTHER'S MAIDEN NAME: MARY E. HARDESTY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: RICHARD WARD — Address: LOTHIAN, Md

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 mos.
DUE TO
600.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Pyonephrosis, bilat — 1 mo.
DUE TO
(c):

2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 8, 1959, to Jan. 20, 1960, that I last saw the deceased alive on Jan. 20, 1960, and that death occurred at 7:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edwin Davis, Jr. M.D. — ADDRESS (Street, city or town, state): 98 Cathedral St., Annapolis, Md. — DATE SIGNED: 1/21/60

PHYSICIAN'S NAME (Type): Edwin Davis, Jr.

1

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 1/23/60 — 22c. NAME OF CEMETERY OR CREMATORY: QUAKER — 22d. LOCATION (City, town, or county) (State): GALESVILLE, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Bernard O Hardesty — ADDRESS: Galesville Md

24a. REC'D BY REGISTRAR DATE: JAN 25 '60 — 24b. REGISTRAR'S SIGNATURE: Arthur L. Thrasher

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00140

Item 14 FilmG255 1-29-60 et

1. PLACE OF DEATH 0159
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Laurel Race Track Road

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Scaggsville 13x-2
d. STREET ADDRESS: Rt. 1, Box 283
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Esther — Middle: Geraldine — Last: Harding
4. DATE OF DEATH: Month: January — Day: 21 — Year: 1960
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7-19-15
9. AGE (In years last birthday): 44 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): New York State
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Charles Ginsberg
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Mr. Joseph Daniel Harding (Husband)

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Multiple traumatic injuries	
812x DUE TO (b)		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ ~~CAUSE~~ OF DEATH.
2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Struck by car while lying in road
20c. TIME OF INJURY Hour, e.m.: 12:15xx — Month, Day, Year: 1/21 1960
2Dd. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Road
2Df. (City or town) (County) (State): Laurel, Anne Arundel Co., Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Wm. Yoost M.D.
EXAMINER'S NAME (Type)
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county)
DATE SIGNED: Jan. 21, 1960

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/22/60
22c. NAME OF CEMETERY OR CREMATORY: Emmanuel Cem.
22d. LOCATION (City, town, or country) (State): Scaggsville Md
23. FUNERAL DIRECTOR — ADDRESS: De Witt Donaldson, Laurel, Md
24a. REC'D BY REGISTRAR DATE: JAN 26 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0127 CERTIFICATE OF DEATH

Reg. Dist. No. 00141

M

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis, Md.
c. LENGTH OF STAY IN 1b: 10
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital
063

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 201 Woods Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Anna — Middle: H — Last: Harnish

4. DATE OF DEATH: Month: January — Day: 29 — Year: 19 60

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 11/13/89

9. AGE (In years lost birthday): 70 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Williamsburg Pa

12. CITIZEN OF WHAT COUNTRY? U. S. A

I

13. FATHER'S NAME: George Humphrey

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: V

INFORMANT: Robert A. Harnish — Address: (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRAL HEMORRHAGE OR ANOXIA — INTERVAL BETWEEN ONSET AND DEATH
33/X
DUE TO
(b): ARTERIOSCLEROSIS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): PYLORIC STENOSIS CARCINOMA, FROM LEVT Breast

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-22-, 1960, to 1-29-, 1960, that I last saw the deceased alive on 1-29-, 1960, and that death occurred at 5 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Jesse L. Wilkins M.D. — ADDRESS (Street, city or town, state): 98 Cathedral St. — DATE SIGNED: 1/30/60

1

PHYSICIAN'S NAME (Type): JESSE L. WILKINS — Annapolis, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-2-1960

22c. NAME OF CEMETERY OR CREMATORY: Highland Cemetery

22d. LOCATION (City, town, or county) (State): Lock Haven Pa

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Sayler Sons — ADDRESS: Annapolis Md

24a. REC'D BY REGISTRAR — DATE: FEB 2 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00142
Reg. Dist. No.

0160

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jessup
c. LENGTH OF STAY IN 1b: 40 yrs
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Jessup
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY Middle E. Lost HEBRON

4. DATE OF DEATH: Month Jan. Day 11, Year 1960

5. SEX: female
6. COLOR OR RACE: colored
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: April 6, 1895
9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laundress (Domestic)
10b. KIND OF BUSINESS OR INDUSTRY: Govt.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S. A.

13. FATHER'S NAME: Nathaniel Washington
14. MOTHER'S MAIDEN NAME: Winnie A. Dorsey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Ellen Allen, Jessup, Md. Address (Sister)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma Metastatic — INTERVAL BETWEEN ONSET AND DEATH:
153.0
DUE TO (b): C.a Uterus — 16 mo
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12/23, 1959 to 1/11, 1960, that I last saw the deceased alive on 1/11, 1960, and that death occurred at 10:55 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: B. P. Warren M.D. ADDRESS (Street, city or town, state): Laurel Md DATE SIGNED: 1/11/60
PHYSICIAN'S NAME (Type): B. P. WARREN Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/15/60
22c. NAME OF CEMETERY OR CREMATORY: Church Cemetery,
22d. LOCATION (City, town, or county) (State): Jessup, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Snowden ADDRESS: Rockville, Md.
24a. REC'D BY REGISTRAR DATE: JAN 18 '60
24b. REGISTRAR'S SIGNATURE: Clifton S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

0161 — Reg. Dist. No. 00143

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 13 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 542 N. Carrollton Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Phillip — Middle Lee — Last Holly

4. DATE OF DEATH: Month 1 — Day 19 — Year 1960

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1936

9. AGE (In years last birthday): 24 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (State or foreign country): Unknown

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unknown (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unknown

INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Edema — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
300.2
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Schizophrenia, Catatonic Type
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month — Day — Year 19—

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/6, 1960, to 1/19, 1960, that I last saw the deceased alive on 1/19, 1960, and that death occurred at 12:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Carl B. Schleifer M.D. — ADDRESS (Street, city or town, state): Crownsville State Hospital, Md. — DATE SIGNED: 1/19/60

PHYSICIAN'S NAME (Type): Carl B. Schleifer, M. D. — Crownsville State Hospital, Md. — 1/19/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1-23-60
22c. NAME OF CEMETERY OR CREMATORY: Arbutus Mem. Cem.
22d. LOCATION (City, town, or county) (State): Arbutus, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: William A. Jackson INC. — ADDRESS: 916 Penna. ave. Balto. Md.

24a. REC'D BY REGISTRAR DATE: JAN 25 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1,8 Film G254 1-14-60 et

CERTIFICATE OF DEATH

0162

Reg. Dist. No. 00144

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Box 299, Millersville — COUNTY: Anne Arundel

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville

c. LENGTH OF STAY IN 1b: 60 years

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Millersville

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sanns Nursing Home

d. STREET ADDRESS: Jumper Hole Rd., Box 299, Millersville

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ada — Middle: Irene — Last: HORKY

4. DATE OF DEATH: Month: January — Day: 6 — Year: 19 60

5. SEX: F

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4-26-1896 1895

9. AGE (In years last birthday): 64 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Millersville, Md.

12. CITIZEN OF WHAT COUNTRY? Yes

13. FATHER'S NAME: Benjamin William DUVALL

14. MOTHER'S MAIDEN NAME: Sarah Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: ---

17. INFORMANT: daughter Mrs Dorothy Mace — Address: Earleigh Heights, Severna Park, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Nephritis - acute — INTERVAL BETWEEN ONSET AND DEATH: 6 mo

DUE TO (b): Diabetes — 3 yr.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cancer - lft shldr. 3 yrs.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): No accident

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7-9, 1959 to 12-22, 1959, that I last saw the deceased alive on 12-22, 1959, and that death occurred at 2:30 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: H.F. Manuzak M.D. — ADDRESS (Street, city or town, state): Glen Burnie, Md. — DATE SIGNED: 1-6-60

PHYSICIAN'S NAME (Type): H.F. MANUZAK, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): B

22b. DATE THEREOF: 1-9-60

22c. NAME OF CEMETERY OR CREMATORY: Glen Haven

22d. LOCATION (City, town, or county) (State): Balto.

23. FUNERAL DIRECTOR'S SIGNATURE: McCully - 130 E. Fort Ave. — ADDRESS

24a. REC'D BY REGISTRAR DATE: JAN 8 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0163 CERTIFICATE OF DEATH

00145

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundal — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie

c. LENGTH OF STAY IN 1b:

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 100 Cherry Lane Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Anne Arundal

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie

d. STREET ADDRESS: 100 Cherry Lane Road

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Daniel Middle Custer Last Hunt, Sr.

4. DATE OF DEATH: Month 1 Day 4 Year 1960

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 3-3-1878

9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Insurance agent

10b. KIND OF BUSINESS OR INDUSTRY: Southern LifeCo.

11. BIRTHPLACE (State or foreign country): Va.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Daniel Custer Hunt

14. MOTHER'S MAIDEN NAME: Sallie Baker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Dr. Richard Hunt Address: 100 Cherry Lane Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): HYPERTENSIVE CARDIOVASCULAR DISEASE — INTERVAL BETWEEN ONSET AND DEATH: ?

443X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):

DUE TO

(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12-1 1959 to 1-4 1960, that I last saw the deceased alive on 1-4 1960, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas W. Harris M.D. ADDRESS (Street, city or town, state): 1824 W. Franklin St Balto 23rd DATE SIGNED: 1-5-60

PHYSICIAN'S NAME (Type): Thomas W. Harris

22a. BURIAL, CREMATION, REMOVAL (Specify): B

22b. DATE THEREOF: 1-7-59

22c. NAME OF CEMETERY OR CREMATORY: MT. AUBURN

22d. LOCATION (City, town, or county) (State): Baltimore

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John M. Johnson-1700 Druid Hill Avenue

24a. REC'D BY REGISTRAR DATE: JAN 6 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Timm

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

0128

Reg. Dist. No. 00146

1. PLACE OF DEATH
a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 25 Franklin St

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 1 25 Franklin St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Blanche Middle Bower Last Jackson

4. DATE OF DEATH: Month 1 — Day 4 — Year 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 19th 1886

9. AGE (In years last birthday): 73 yrs.

IF UNDER 1 YEAR / IF UNDER 24 HRS.: Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Hagerstown Md

12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME: John Henry Bower

14. MOTHER'S MAIDEN NAME: Mary Elizabeth Sneman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Elmer M. Jackson Jr. — Address: Wardour Annapolis Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Congestive Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: Several Hours

592 x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Sub-Acute Myocarditis with Pulmonary Congestion — Several Months

DUE TO (c): Cronic Nefritis — Several Months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9-12-, 1959, to 1-4-, 1960, that I last saw the deceased alive on 12-15-, 1959, and that death occurred at 7 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J. Oliver Purvis M.D. — ADDRESS (Street, city or town, state): 40 Fresh Air St. Annapolis Md — DATE SIGNED: 1/4/60

PHYSICIAN'S NAME (Type): J OLIVER PURVIS ANNAPOLIS MARYLAND.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1-6-60

22c. NAME OF CEMETERY OR CREMATORY: St Annes Cemt

22d. LOCATION (City, town, or county) (State): Annapolis Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons — ADDRESS: Annapolis Md

24a. REC'D BY REGISTRAR — DATE: JAN 7 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Kovus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

0164 — Reg. Dist. No. 00147

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 2mo. 7 days
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3V01-4
d. STREET ADDRESS: 1537 Ensor Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Annie; Middle: ; Lost: Jefferson

4. DATE OF DEATH: Month: 1; Day: 25; Year: 1960

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1894 - Oct. 8

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~Unknown~~ Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (State or foreign country): ~~Unknown~~ Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ~~Unknown~~ Patrick Jefferson

14. MOTHER'S MAIDEN NAME: ~~Unknown~~ Christian Sawyer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unknown (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypostatic Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH:
420.1
DUE TO
(b): Myocardial-old and recent Infarction
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO
(c): Arteriosclerotic Cardiovascular + Renal Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cerebral Softening

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ----------

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. — — — 19 —

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — — —

20f. (City or town) (County) (State) — — —

21. I certify that I attended the deceased from 11/18, 1959, to 1/25, 1960, that I last saw the deceased olive on 1/25, 1960, and that deoth occurred at 11:30A. M, fram the causes and an the date stated abave.

ACTUAL SIGNATURE: Hildegard Heard Reiss M.D. — ADDRESS (Street, city or town, state): Crownsville State Hospital, Md. — DATE SIGNED: 1/25/60

PHYSICIAN'S NAME (Type): Hildegard Heard Reissman — Crownsville State Hospital, Md. — 1/25/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1-28-60

22c. NAME OF CEMETERY OR CREMATORY: Mt. Auburn

22d. LOCATION (City, town, or county) (State): Baltimore Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Mrs. Katie A. Williams — ADDRESS: 322 N. Stockton St. Balto. Md.

24a. REC'D BY REGISTRAR DATE: JAN 29 '60

24b. REGISTRAR'S SIGNATURE: Clarence E. Timms

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to buriol, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00148

0165

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville
c. LENGTH OF STAY IN 1b 12 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sauns Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Millersville
d. STREET ADDRESS Dicus Mill Rd -
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First George Middle H. Last Johns

4. DATE OF DEATH Month JAN Day 16 Year 1960

5. SEX M. 6. COLOR OR RACE W 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH (Month, Day, Year) March 15 1877

9. AGE (In years last birthday) 82 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GROCER - Ret.

10b. KIND OF BUSINESS OR INDUSTRY Self-Employed

11. BIRTHPLACE (State or foreign country) PA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Steven Johns

14. MOTHER'S MAIDEN NAME Susan Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. 196-01-5550

17. INFORMANT Ethel J. Luce Address Same as 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure.

DUE TO (b) Sclerotic Hypertensive Cardiovascular Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 443X

DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Supravesical Cystostomy —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1959, to January 16, 1960, that I last saw the deceased alive on 1-12, 1960, and that death occurred at 11 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE Febus Freeman M.D. ADDRESS (Street, city or town, state) P.O Box 37 DATE SIGNED 1/10/60

PHYSICIAN'S NAME (Type) Febus Freeman Odenton Md -

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 1-19-60.

22c. NAME OF CEMETERY OR CREMATORY Forest Hill

22d. LOCATION (City, town, or county) (State) Dumore Lacka Co. Pa.

23. FUNERAL DIRECTOR'S SIGNATURE Hopping & Kirkley ADDRESS Glen Burnie, Md

24a. REC'D BY REGISTRAR DATE JAN 20 '60

24b. REGISTRAR'S SIGNATURE Arthur L. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

0166 — Reg. Dist. No. 00149

1. PLACE OF DEATH
a. COUNTY: A. A. County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mulberry Hill
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: A. A. County
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural
d. STREET ADDRESS: R 4 Box 371 Anna Md.
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Mary A — Middle: — Last: Johnson

4. DATE OF DEATH: Month: 1 — Day: 21 — Year: 1960

5. SEX: Female
6. COLOR OR RACE: Col
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10-16-1896
9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel L. Colbert
14. MOTHER'S MAIDEN NAME: Catherine Walker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
INFORMANT: Ceasar Johnson
Address: R 4 Box 371 Anna Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Cardiac Failure
DUE TO
4341
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour: o. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9-15- 19 59 to 1-21-60 19 ___, that I last saw the deceased alive on 1-19-60 19 ___, and that death occurred at 2:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE OF M.D.: A. T. Allen
ADDRESS (Street, city or town, state): 62 Cathedral St
DATE SIGNED:
PHYSICIAN'S NAME (Type): A T ALLEN
Annapolis, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1-24-1960
22c. NAME OF CEMETERY OR CREMATORY: Broadneck
22d. LOCATION (City, town, or county) (State): A. A. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Reese
ADDRESS: Anna Md.
24a. REC'D BY REGISTRAR
DATE: JAN 25 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

0167 — 00150 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 5mo. 13 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 1 75 Pleasant Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Shirley — Middle: — Last: Johnson

4. DATE OF DEATH: Month: 1 — Day: 26 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: February 24,1884

9. AGE (In years last birthday): 75 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed

10b. KIND OF BUSINESS OR INDUSTRY: ---------

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 216-10-5872

17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia Hypostatic — 422.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Congestive Heart Failure
DUE TO
(c): Arteriosclerotic Cardiovascular Disease

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour — o. m. / p. m. — Month, Day, Year — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/13, 1959, to 1/26, 1960, that I last saw the deceased alive on 1/26, 1960, and that death occurred at 10:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp M.D. — ADDRESS (Street, city or town, state): Crownsville State Hospital, Md. — DATE SIGNED: 1/27/60

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp — Crownsville State Hospital, Md. — 1/27/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1-30-60

22c. NAME OF CEMETERY OR CREMATORY: Mt. Auburn

22d. LOCATION (City, town, or county) (State): Baltimore Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Reese D — ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR — DATE: JAN 28 '60

24b. REGISTRAR'S SIGNATURE: Emma S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

0168 — Reg. Dist. No. 00151

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Plaza Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 17, Maryland 3V01-4
d. STREET ADDRESS: 1410 McCulloh Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SUSIE Middle JOHNSON Lost

4. DATE OF DEATH: Month January Day 8, Year 1960

5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12-25-1886
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic worker
10b. KIND OF BUSINESS OR INDUSTRY: Pvt. Family
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Nathan Henry
14. MOTHER'S MAIDEN NAME: Charlotte Roy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Earl Fitchette Address: 2005 Bryant Ave. City 17

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Generalized arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: ? yrs.
450.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Senile dementia
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12-30- 1959 to 1-8- 1960 that I last saw the deceased alive on January 2, 1960, and that death occurred at 4:30A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James M. Pair M.D. — ADDRESS (Street, city or town, state): 400 N. Carrollton Avenue — DATE SIGNED: 1-8-1960

PHYSICIAN'S NAME (Type): James M. Pair, M.D. — Baltimore 23, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/12/60
22c. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cemetery
22d. LOCATION (City, town, or county) (State): Baltimore Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Herbert E. Nutter -3810 Bonner Road
24a. REC'D BY REGISTRAR DATE: JAN 13 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kress

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06152

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 3 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 25 Stevens Rd. Glenwood

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Same — b. COUNTY: Same
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): × Same
d. STREET ADDRESS: Same
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: E. — Last: Justice

4. DATE OF DEATH: Month: January — Day: 5th, — Year: 19 60

5. SEX: F
6. COLOR OR RACE: W.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5/3/27
9. AGE (In years last birthday): 32 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: DOMESTIC
11. BIRTHPLACE (State or foreign country): New York, N.Y.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WALTER Gallagher
14. MOTHER'S MAIDEN NAME: UnKnown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): NONE
16. SOCIAL SECURITY NO.: ?
17. INFORMANT — Address: Frances McCormick (daughter) age 12.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Laennec's cirrhosis with gastro-intestinal hemorrhage — INTERVAL BETWEEN ONSET AND DEATH:
581.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year: 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: W Bradley King Jr. M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED: 1/6/60

EXAMINER'S NAME (Type): W. Bradley King, Jr., M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 1-11-60
22c. NAME OF CEMETERY OR CREMATORY: GLEN HAVEN
22d. LOCATION (City, town, or county) (State): Anne Arundel Cty, Md

23. FUNERAL DIRECTOR'S SIGNATURE: GEO. L. SCHWAB FUNERAL HOME
ADDRESS: Francis W. Miller 2101 Frederick Ave.
24a. REC'D BY REGISTRAR — DATE: JAN 11 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

0170

Reg. Dist. No. 00153

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater md
c. LENGTH OF STAY IN 1b: 7 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel County Home

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Selby, a a Co.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: William — Middle: — Last: Cuba

4. DATE OF DEATH: Month: January — Day: 22 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug. 4 1870

9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months | Days | Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Unknown

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 month
422.1
DUE TO (b): Arteriosclerotic Cardiovascular Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour o. m. / p. m.; 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from October, 1959 to January 22, 1960, that I last saw the deceased alive on Jan 19, 1960, and that death occurred at 3:30 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Maurice F. Klawans M.D. — ADDRESS (Street, city or town, state): 31 Smithgate Ln — DATE SIGNED: 1/25/60

PHYSICIAN'S NAME (Type): MAURICE F. KLAWANS — Annapolis Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1/23/60

22c. NAME OF CEMETERY OR CREMATORY: County Home

22d. LOCATION (City, town, or county): Edgewater (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Bernard O Hardesty — ADDRESS: Galesville Md

24a. REC'D BY REGISTRAR — DATE: JAN 28 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0143 **CERTIFICATE OF DEATH** 00154

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION md

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Dividing RD.
d. STREET ADDRESS Severna Park md
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Mary Middle Rebecca Last Fork
4. DATE OF DEATH Month 1 Day 4 Year 1960
5. SEX F
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH June 6, 1872
9. AGE (In years last birthday) 87 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Baltimore md
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME James Edward Shipley
14. MOTHER'S MAIDEN NAME "Unk"
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO.
17. INFORMANT Daughter - Mrs Harley Myers #2 Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage
331x
DUE TO (b) Generalized Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1955, 19____, to 1960, 19____, that I last saw the deceased alive on 1-1-60, 19____, and that death occurred at 11 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE Robert R Halm M.D. ADDRESS (Street, city or town, state) Severna Park md DATE SIGNED 1-4-60
PHYSICIAN'S NAME (Type) Robert R. Halm md

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 1-7-1960
22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL
22d. LOCATION (City, town, or county) BROOKLYN (State) MD.

23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor & Son ADDRESS Annapolis, Md.
24a. REC'D BY REGISTRAR DATE JAN 7 '60
24b. REGISTRAR'S SIGNATURE Outland L. Kramer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00155

0129 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b: 15 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X ANNAPOLIS
d. STREET ADDRESS: RT-1, EPPING FOREST ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JULIA — Middle CHARLOTTE — Last LARSEN

4. DATE OF DEATH: Month 1 — Day 28 — Year 1960

5. SEX: FEMALE

6. COLOR OR RACE: CAUC.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8-25-84

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWNE HOME

11. BIRTHPLACE (State or foreign country): WISCONSIN

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: PETER JENSEN

14. MOTHER'S MAIDEN NAME: (UNKNOWN)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 391 09 0719

17. INFORMANT: (DAUGHTER) IRENE C. GRUNTOWICZ, RD., ANNAPOLIS, MD.
Address: RT-1, EPPING FOREST

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): INFLAMMATORY CELL CARCINOMA RT. BREAST
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH: 4 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 14 January, 1960, to 1-28, 1960, that I last saw the deceased alive on 28 January, 1960, and that death occurred at 2:10 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: R. C. Laning M.D. — ADDRESS (Street, city or town, state): U.S. NAVAL HOSPITAL, ANNAPOLIS, MD. — DATE SIGNED: 1-29-60

PHYSICIAN'S NAME (Type): R. C. LANING LCDR MC USN — U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb. 1, 1960
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Memorial Cemet.
22d. LOCATION (City, town, or county) (State): Annapolis, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: Hopping Funeral Home, Annapolis, Maryland

24a. REC'D BY REGISTRAR — DATE: FEB 2 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Hearn

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0130 CERTIFICATE OF DEATH

Reg. Dist. No. 00156

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 16 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural - Crownsville
d. STREET ADDRESS: Herald Harbor
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First EDYTHE Edith — Middle IRENE — Last MACKENZIE

4. DATE OF DEATH: Month January — Day 31 — Year 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: November 12, 1885
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 577 07 3982
INFORMANT — Address: Hospital Record Office

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ca of kidney Anaplastic Hypernephroma type — INTERVAL BETWEEN ONSET AND DEATH: 10 years
DUE TO
(b): with Metastases to bones
DUE TO
(c): multiple pathologic fractures
180x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hypertensive CVD
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, form, factary, street, affice bldg., etc.)
20f. (City or tawn) (County) (State)

21. I certify thot I ottended the deceosed from January 15, 1960, to 1-31, 1960, thot I last sow the deceased alive on 1-30, 1960, and that death occurred at 8:15A.M, from the causes ond on the dote stoted above.

ACTUAL SIGNATURE: Edith Rodler, M.D. — ADDRESS (Street, city or town, state): 45 Franklin St., Annapolis, Md. — DATE SIGNED: 2/1/60

PHYSICIAN'S NAME (Type): Edith Rodler

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: Feb. 3, 1960
22c. NAME OF CEMETERY OR CREMATORY: Congressional Cemetery
22d. LOCATION (City, town, or county) (State): Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Hopping Funeral Home — ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR DATE: FEB 3 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Hanna

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

Item 20 Film 259 1-29-60 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00157

Reg. Dist. No. 0132

1. PLACE OF DEATH
a. COUNTY: A.A. Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A. Home Hrundel Gen.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: New Jersey — b. COUNTY: Mercer
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Trenton 67x9
d. STREET ADDRESS: Rt. 1 - Bakers Basin Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First MARY — Middle — Last HAZUR

4. DATE OF DEATH: Month 1 — Day 18 — Year 1960

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 1-3-1912

9. AGE (In years last birthday): 48 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): POLAND

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Anthony Wiater

14. MOTHER'S MAIDEN NAME: Julia Jaworska

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital Record — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fracture Skull — INTERVAL BETWEEN ONSET AND DEATH: Sudden
816 X
DUE TO (b): Whiplash injury neck
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ **CAUSE OF DEATH.**

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Auto accident - auto struck trailor tractor

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year: 1-18 1960

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway

20f. (City or town): — (County): A.A. (State): MD

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: O Linhardt M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 1/18/60

EXAMINER'S NAME (Type): E. Linhardt

22a. BURIAL, ~~CREMATION, REMOVAL~~ (Specify) — **22b. DATE THEREOF**: 1-20-1960 — **22c. NAME OF CEMETERY OR CREMATORY**: St. Hedwigs Cem — **22d. LOCATION** (City, town, or county): Ewing Township (State): N.J.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor — **ADDRESS**: 500 Annapolis MD

24a. REC'D BY REGISTRAR DATE: JAN 20 '60 — **24b. REGISTRAR'S SIGNATURE**: Arthur S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

0171 — 00158 — Reg. Dist. No. 27

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort George G. Meade
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Army Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Pasadena
d. STREET ADDRESS: Mountain Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FOSTER — Middle K. — Last McLEROY JR

4. DATE OF DEATH: Month January — Day 27 — Year 19 60

5. SEX: Male

6. COLOR OR RACE: Cau

7. MARRIED ☐ NEVER MARRIED ■ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 28 September 59

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months 4 — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ----------

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Anchorage, Alaska

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Foster K. McLeroy

14. MOTHER'S MAIDEN NAME: Sandra J. Humphries

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): ----------

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: Father — Address: Pasadena, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 3 hours

7545

DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Respiratory Infection — 3 days
DUE TO
(c) Congenital Heart Disease — Since Birth

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 27 January, 1960, to 27 January, 1960, that I last saw the deceased alive on 27 January, 1960, and that death occurred at 8:25 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Norman B. Sher M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED: 27 Jan 60

PHYSICIAN'S NAME (Type): NORMAN B. SHER, CAPT., MC — U.S. Army Hospital, Fort Geo G. Meade, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 29 Jan. 60
22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Cemetery
22d. LOCATION (City, town, or county) (State): Glen Burnie, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: R. V. Singleton — ADDRESS: Glen Burnie, Md

24a. REC'D BY REGISTRAR DATE: FEB 2 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

9VVVVVVXVV

1

Item 18 Film 255 2-8-60 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00159

1. PLACE OF DEATH
a. COUNTY: Anne ArundelCouty 0172 MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jessup
c. LENGTH OF STAY IN 1b: 4 mos.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Maryland House of Correction

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: St. Mary's ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ? 18 X-2
d. STREET ADDRESS: ?
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

092

3. NAME OF DECEASED (Type or print): First John; Middle Henry; Last Milburn
4. DATE OF DEATH: Month January; Day 12; Year 1960

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 11/8/20
9. AGE (In years last birthday): 39 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): St. Mary's County, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Milburn
14. MOTHER'S MAIDEN NAME: Anna Mae Russell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Merchant Marines
16. SOCIAL SECURITY NO.: 216-07-8243
17. INFORMANT Address: Md. House of Correction Records, Jessup, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Viral pneumonitis, acute, severe — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b):
DUE TO (c):

492X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m.; Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: W. Bradley King, Jr. M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DATE SIGNED: 1/13/60
EXAMINER'S NAME (Type): W. Bradley King, Jr., M.D.
DEPUTY MEDICAL EXAMINER ☐

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1'14'60
22c. NAME OF CEMETERY OR CREMATORY: St. Peters Cemetery
22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Howard H. Hubbard 4107 Wilkens Avenue
24a. REC'D BY REGISTRAR DATE: JAN 15 '60
24b. REGISTRAR'S SIGNATURE: Emma S. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

00160

0173

CERTIFICATE OF DEATH

Item 12 File 4255 2-1-60 et

1. PLACE OF DEATH
a. COUNTY: Anne Arundel Co., MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Plaza Manor

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3V01-4
d. STREET ADDRESS: 1706 Westwood Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐*

3. NAME OF DECEASED (Type or print): First Huey Middle A. Last Molok

4. DATE OF DEATH: Month January Day 23, Year 1960

5. SEX: Male

6. COLOR OR RACE: Col

7. MARRIED ☐ NEVER MARRIED ☐* WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: December 28, 1889

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Butler

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Ontanio Canada

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Francis Molok

14. MOTHER'S MAIDEN NAME: Mary Howard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): -
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: 215-22-2705

17. INFORMANT: Marjorie Ockimey Address: 1706 Westwood Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic and hypertensive cardiovascular disease. — INTERVAL BETWEEN ONSET AND DEATH: over 10 yrs.
443X
DUE TO (b):
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Doy, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from December 11 1959, to January 23, 1960, that (I) (we) last saw the deceased alive on January 16 1960, and that death occurred at 4:45 A.M., from the causes and on the date stated above.

22a. SIGNATURE: James M. Pair M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: January 25, 1960

22c. PHYSICIAN'S NAME (Type): James M. Pair, M.D.

22d. ADDRESS: 400 N. Carrollton Ave. Balto. 23, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1-27-1960
23c. NAME OF CEMETERY OR CREMATORY: Arbutus Memorial
23d. LOCATION (City, town, or county) (State): Arbutus, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Arlington S. Phillips 1808N. Monroe St.

25a. REC'D BY REGISTRAR DATE: JAN 27 '60

25b. REGISTRAR'S SIGNATURE: Curtis L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4) 15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0174 **CERTIFICATE OF DEATH** 00161

Reg. Dist. No.

M

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 8mo. 1 yr. 10 days
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceosed lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3V01,4
d. STREET ADDRESS: 737 W. Franklin Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

010

3. NAME OF DECEASED (Type or print): First: Robert; Middle: Henry; Last: Monroe

4. DATE OF DEATH: Month: 1; Day: 12; Year: 19 60

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED (Sep.)? NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 13, 1889

9. AGE (In years last birthday): 70 yrs.

IF UNDER 1 YEAR: Months; Doys — IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: -------

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

I

13. FATHER'S NAME: Frank Monroe

14. MOTHER'S MAIDEN NAME: Mary Shields

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give wor or dates of service): No

16. SOCIAL SECURITY NO.: 213-09-7178

INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Heart Failure

422.1

Conditions, if any, which gave rise to immediate couse (a), staling the underlying cause last.

DUE TO (b): Arteriosclerotic Cardiovascular Disease

DUE TO (c): Generalized Arteriosclerosis, Severe

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.) ----------

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. ---

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---

20f. (City or town) (County) (State) ---

21. I **certify** that I attended the deceased from 5/2, 19 58, to 1/12, 19 60, that I last saw the deceased alive an 1/12, 1960, and that death accurred at 1:30P.M. fram the causes and an the date stated abave.

ACTUAL SIGNATURE: Hildegard Heard Reissman M.D. — ADDRESS (Street, city or town, state): Crownsville State Hospital, Md. — DATE SIGNED: 1/13/60

1

PHYSICIAN'S NAME (Type): Hildegard Heard Reissman, M. D. — Crownsville State Hospital, Md. — 1/13/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1/16/60

22c. NAME OF CEMETERY OR CREMATORY: Mt Lebanon

22d. LOCATION (City, town, or county) (State): Baltimore Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Charles A. Rice & Wm Bare — ADDRESS: [illegible]

24a. REC'D BY REGISTRAR DATE: JAN 15 '60

24b. REGISTRAR'S SIGNATURE: Chas S. Mans

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registror priar to buriol, cremation, ar removol, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00162

0175 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. **PLACE OF DEATH**
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort George G. Meade
c. LENGTH OF STAY IN 1b: 1 Day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Army Hospital

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severn
d. STREET ADDRESS: Brodsky's Trailer Park
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Not Named — Middle: — Last: Moore

4. **DATE OF DEATH**: Month: January — Day: 10 — Year: 1960

5. SEX: Female

6. COLOR OR RACE: Cau

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9 January '60

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months: — Days: 1 — IF UNDER 24 HRS.: Hours: 2 — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Kenneth James Moore

14. MOTHER'S MAIDEN NAME: Karen Madara

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

INFORMANT: Mother — Address: Brodsky's Trailer Park, Severn, Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 26 hours
DUE TO
762.5
Conditions, if ony, which gave rise to immediate couse (a), stating the underlying cause last.
(b): Prematurity
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Doy, Yeor 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from 9 January, 1960, to 10 January, 1960, that I last saw the deceased alive on 10 January, 1960, and that death occurred at 2:30 P.M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE: Roger C Moyer Capt MC M.D.

PHYSICIAN'S NAME (Type): ROGER C. MOYER, CAPT., MC, US Army Hospital, Fort George G. Meade, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Cremation	11 Jan 1960	Laboratory, U.S. Army Hospital	Ft Geo G. Meade, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Betty M. Ellis Capt MSC — ADDRESS: BETTY M. ELLIS, Capt., MSC USAH, Fort Geo G Meade, Md

24a. REC'D BY REGISTRAR DATE: JAN 13 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

2050171XV2

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0176 **CERTIFICATE OF DEATH** 00163

Reg. Dist. No.

1. **PLACE OF DEATH**
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MILLERSVILLE
c. LENGTH OF STAY IN 1b: 3Mo. 7 DAYS
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: SANN'S NURSING HOME

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: A.A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X EDGEWATER
d. STREET ADDRESS: CHESTNUT HILL
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. **NAME OF DECEASED** (Type or print): First: Dora — Middle: T. — Last: Moore

4. **DATE OF DEATH**: Month: Jan 11 — Day — Year: 1960

5. SEX: M

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: SEPT. 2-1878

9. AGE (In years lost birthday): 81 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY: FARMING

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: SILAS H. MOORE

14. MOTHER'S MAIDEN NAME: SOPHIA DAVIS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT: MARY NEWBERGER, Address: MILLERSVILLE

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Lobar Pneumonia — Interval between onset and death: 10 days

DUE TO (b): Generalized Arteriolars — 3 years

DUE TO (c): Paralysis - Residual — 1 year

Conditions, if ony, which gave rise to immediate couse (a), stoting the underlying couse lost.

4500

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Senility - Parkenson Syndrome.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 4, 1959 to Jan 11-60, that I last saw the deceased alive on Jan 11-, 1960, and that death occurred at 12:30 P.M. from the causes and an the date stated above.

ACTUAL SIGNATURE: Joseph Lipsky M.D.

ADDRESS (Street, city or town, State): Edgewater

DATE SIGNED: 1/11/60

PHYSICIAN'S NAME (Type): JOSEPH LIPSKEY

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 1-16-60

22c. NAME OF CEMETERY OR CREMATORY: WOODLAND CEM.

22d. LOCATION (City, town, or county): BELLPORT LONG ISL. (State): N.Y.

23. FUNERAL DIRECTOR'S SIGNATURE: JOHN M. TAYLOR SON — ADDRESS: ANNAPOLIS MD.

24a. REC'D BY REGISTRAR DATE: JAN 14 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar priar to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

0177 — Reg. Dist. No. 00164

1. PLACE OF DEATH
a. COUNTY: aa — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jewell Rd
c. LENGTH OF STAY IN 1b: 60 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: aa
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jewell
d. STREET ADDRESS: Dunkirk PO
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Kate — Middle: Belle — Last: Moreland
4. DATE OF DEATH: Month: 7 — Day: — Year: 1960
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Sept 6, 1863
9. AGE (In years last birthday): 96 yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Md Lower Marlboro
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Wm Henry Kedrymple
14. MOTHER'S MAIDEN NAME: Eliza Ward
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Cora Phipps — Address: Jewell, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 6 days
782.4
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 2, 1960, to Jan 7, 1960, that I last saw the deceased alive on Jan 7, 1960, and that death occurred at 2:30 P M, from the causes and on the date stated above.
ACTUAL SIGNATURE: H W Ward M.D.
ADDRESS (Street, city or town, state): Oamp Md
DATE SIGNED: 1/7/60
PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Jan 10/60
22c. NAME OF CEMETERY OR CREMATORY: Friendship
22d. LOCATION (City, town, or county): FRIENDSHIP (State): MD

23. FUNERAL DIRECTOR'S SIGNATURE: Burnett Hardesty — ADDRESS: Hillsville Md

24a. REC'D BY REGISTRAR DATE: JAN 12 '60
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item #2-FilmG254-1/15/60-mb

00166

CERTIFICATE OF DEATH

0178

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville
c. LENGTH OF STAY IN 1b 5 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, 16 3V01.4
d. STREET ADDRESS 1405 Bloomingdale Rd. Baptist Home 1947 City Hospital 2301 Reynolds Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Sallie Middle Last Morton
4. DATE OF DEATH Month January Day 10 Year 1960
5. SEX Female
6. COLOR OR RACE negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 1884
9. AGE (In years last birthday) 75 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?
10b. KIND OF BUSINESS OR INDUSTRY ?
11. BIRTHPLACE (State or foreign country) VA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Medical records Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Circulatory insufficiency. 450.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) generalized arteriosclerosis
DUE TO
(c) Aging

INTERVAL BETWEEN ONSET AND DEATH 5 days.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 1- advanced cerebral arteriosclerosis 2 - Blind

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 8, 1960, to January 10, 1960, that I last saw the deceased alive on January 10, 1960, and that death occurred at 6:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Lieut. M.D. Sig. Mapp M.D.
ADDRESS (Street, city or town, state) Crownsville State Hospital
DATE SIGNED
PHYSICIAN'S NAME (Type) Lieut. M.D. Henry Mapp
Crownsville Md

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 1/14/60
22c. NAME OF CEMETERY OR CREMATORY Mt Calvary
22d. LOCATION (City, town, or county) (State) Brooklyn - md

23. FUNERAL DIRECTOR'S SIGNATURE Marshall P. Hayes
ADDRESS 6385 S. Glynn Ave Baltimore 17 Md

24a. REC'D BY REGISTRAR DATE JAN 12 '60
24b. REGISTRAR'S SIGNATURE Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0179 CERTIFICATE OF DEATH

Reg. Dist. No. 00167

1. PLACE OF DEATH
a. COUNTY: Anundel. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural
c. LENGTH OF STAY IN 1b: 45 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Anundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x Glen Burnie R.F.D. No 3
d. STREET ADDRESS: 2101 Ritchie Highway South
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First THEOPHANO — Middle — Last MOUSHABEK

4. DATE OF DEATH: Month Jan. — Day 11 — Year 1960

5. SEX: Female
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: 1891
9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Jerusalem
12. CITIZEN OF WHAT COUNTRY? Jerusalem

13. FATHER'S NAME: FOTE THEODORE
14. MOTHER'S MAIDEN NAME: THEODORI

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: no
INFORMANT: Eleanor J. Moushabek — Address: 2101 S. Ritchie Highway, Glen Burnie

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary thrombosis. — INTERVAL BETWEEN ONSET AND DEATH
420.0
DUE TO (b): Arteriosclerotic heart disease.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from Nov. 30, 1959, to Jan. 11, 1960 that I last saw the deceased alive on Jan. 11, 1960, and that death occurred at 10:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmond J. Moushabek M.D. — ADDRESS (Street, city or town, state): 2101 S. Ritchie Highway Glen Burnie Maryland — DATE SIGNED: Jan. 11, 60

PHYSICIAN'S NAME (Type): EDMOND I. MOUSHABEK.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Jan 12-60
22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Cemetery
22d. LOCATION (City, town, or county) (State): Ritchie Hwy Glen Burnie Md

23. FUNERAL DIRECTOR'S SIGNATURE: Edward A Funk — ADDRESS: Glen Burnie Md

24a. REC'D BY REGISTRAR DATE: JAN 15 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be affixed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00168

Reg. Dist. No. 0132

1. PLACE OF DEATH
a. COUNTY ANNE ARUNDEL MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 ANNAPOLIS
d. STREET ADDRESS Quarters D, Nav. Exp. Sta.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Robert	Lutes	MOYER	1	18	1960

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
M	Cauc.		12 June 1919	40 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
U.S. NAVY	ARMED FORCES	Montana	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Willard W. Moyer	Ethel Lutes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes WW II	****	Wife: Gene E. Moyer NAVAL EXP. STATION Qtrs. D, U.S.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

420.1

Conditians, if any, which gave rise to immediate couse (a), stating the underlying couse last.

DUE TO (b) Thrombosis, Circumflex Coronary Artery

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o): Pulmonary edema and congestion

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE [signature] M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED 18 January 1960

EXAMINER'S NAME (Type) E. Lewbart

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	1-20-60	U.S.Naval Academy Cemetery,	Annapolis, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Wm. C ok, Inc., 1217 St. Paul Street	JAN 20 '60	Arthur L. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0180 **CERTIFICATE OF DEATH**

00169
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SUNSET BEACH
c. LENGTH OF STAY IN 1b: 3 WEEKS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 8 GRANADA ROAD

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: /
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BALTIMORE 3V01-4
d. STREET ADDRESS: 325 SOUTH WOODYEAR
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First AMANDA (MANDA) Middle A Last MRVICHIN

4. DATE OF DEATH: Month JAN Day 13 Year 1960

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: SEPT. 30, 1883

9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RESTURANT

10b. KIND OF BUSINESS OR INDUSTRY: RESTAURANT

11. BIRTHPLACE (State or foreign country): YUGO-SLAVIA

12. CITIZEN OF WHAT COUNTRY? YUGO-SLAVIA

13. FATHER'S NAME: ALABER

14. MOTHER'S MAIDEN NAME: ~~BENNIE MARCHIN~~ 8 GRANADA ROAD PASADENA, MD.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-03-1907A

17. INFORMANT: BENNIE MARCHIN
Address: 8 GRANADA ROAD PASADENA, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARCINOMA LIVER — INTERVAL BETWEEN ONSET AND DEATH: 3 MONTHS
156.1
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 12/30, 1959, to 1/13, 1960, that I last saw the deceased alive on 1/13, 1960, and that death occurred at 7:25 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J. Brady Smith M.D.
ADDRESS (Street, city or town, state): 8471 FT. SMALLWOOD ROAD
DATE SIGNED: 1/13/60

PHYSICIAN'S NAME (Type): J. BRADY SMITH — PASADENA, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 1-16-1960
22c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem
22d. LOCATION (City, town, or county) (State): Frederick Rd Balto. Md

23. FUNERAL DIRECTOR'S SIGNATURE: THOMAS J. KENNY INC.
ADDRESS: 1600 Hollins St

24a. REC'D BY REGISTRAR DATE: JAN 15 '60
24b. REGISTRAR'S SIGNATURE: Clinton S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00170

0181

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 5mo. 4 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3 V 01-4
d. STREET ADDRESS: 940 Stoddard Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): ~~Rhod~~ First: Rodney Middle: Simon Last: Murdock

4. DATE OF DEATH: Month: 1 Day: 10 Year: 1960

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1890?

9. AGE (In years last birthday): 70? yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Garfield Davenport

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: Unknown

INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular Disease
422.1
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic Brain Syndrome due to Arteriosclerosis - Amputation of left leg

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): ----------

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. ----- 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 8/6, 19 59, to 1/10, 19 60, that I last saw the deceased alive on 1/10, 19 60, and that death occurred at 5:10 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Hildegard Heard Reissman M.D.
ADDRESS (Street, city or town, state): Crownsville State Hospital, Md.
DATE SIGNED: 1/11/60

PHYSICIAN'S NAME (Type): Hildegard Heard Reissman, M. D.
Crownsville State Hospital, Md. 1/11/60

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 1-15-59

22c. NAME OF CEMETERY OR CREMATORY: Mt. Auburn

22d. LOCATION (City, town, or county) (State): Baltimore Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Halstead & March
ADDRESS: 918 D Hill Ave City

24a. REC'D BY REGISTRAR DATE: JAN 14 '60

24b. REGISTRAR'S SIGNATURE: Corinne L. Evans

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 22b, Film G-255 1/29/60.cac.

00171

0142

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riviera Beach
c. LENGTH OF STAY IN 1b: 2 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Greenway Rd - 8476

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riviera Beach.
d. STREET ADDRESS: 8476 Greenway Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELLA Middle VIRGINIA Last MURPHY

4. DATE OF DEATH: Month January Day 27 Year 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 14, 1888

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): ~~Balt~~ Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Hansen Edenfield

14. MOTHER'S MAIDEN NAME: IDA KIRWAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: MRS. MARGARET HARRISON — Address: PASADENA, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cardio-vascular disease — INTERVAL BETWEEN ONSET AND DEATH: 2 years
422.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Generalized arteriosclerosis — 3 years
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Acute virus infection

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 1, 1957 to January 27, 1960 that I last saw the deceased alive on January 26, 1960, and that death occurred at 9:00 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Randall M. McLaughlin M.D.
ADDRESS (Street, city or town, state): RFD 8 Box 442 Pasadena, Md.
DATE SIGNED: Jan. 29, 1960

PHYSICIAN'S NAME (Type): R. M. McLaughlin

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/30/60 2-1-60
22c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery
22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Wm. J. Tuckper & Sons
ADDRESS: Balto - 17, Md.

24a. REC'D BY REGISTRAR
DATE: JAN 29 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00172

0133 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 12 Cathedral St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 12 Cathedral St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary Middle: E. Last: Myers

4. DATE OF DEATH: Month: 1 Day: 25 Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Apr. 22 - 1875

9. AGE (In years last birthday): 84 yrs.

IF UNDER 1 YEAR / IF UNDER 24 HRS.: Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Annapolis Md

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John Sible

14. MOTHER'S MAIDEN NAME: Georganna Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: T. Derf Myers — Address: (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 Days.

491 X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ARTERIOSCLEROTIC HEART DISEASE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year / Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 1959 to 25 Jan. 1960, that I last saw the deceased alive on 26 Jan. 1960, and that death occurred at 4 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward S. Burke M.D. — ADDRESS (Street, city or town, state): 4 Southgate Ave Annapolis, Md — DATE SIGNED: 1/26/60

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1-27-60

22c. NAME OF CEMETERY OR CREMATORY: Cedar Bluff Cem.

22d. LOCATION (City, town, or county): Annapolis (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons — ADDRESS: Annapolis Md

24a. REC'D BY REGISTRAR DATE: JAN 28 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

0182 00173

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 12 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 1603 Kimber Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x Glen Burnie
d. STREET ADDRESS: 1603 Kimber Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First ALLEN Middle OREM Last NEALL

4. DATE OF DEATH: Month 1 Day 18 Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11 July 1910

9. AGE (In years last birthday): 49 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supervisor

10b. KIND OF BUSINESS OR INDUSTRY: Dept. Emp. Sec. of Md.

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Walter R. Neall

14. MOTHER'S MAIDEN NAME: Grace McKinley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): W.W.II

16. SOCIAL SECURITY NO.: 215-07-3181

17. INFORMANT: Mrs. Dorothy M. Mewshaw
Address: Same As #7

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH: 15 mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1953, to JANUARY, 1960, that I last saw the deceased alive on January 10, 1960, and that death occurred at 11 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R MacDonald MD M.D.
ADDRESS (Street, city or town, state): 204 Crain Hwy So Glen Burnie
DATE SIGNED: 1-19-60

PHYSICIAN'S NAME (Type): C. R. MacDonald
Glen Burnie, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 22 Jan. 1960
22c. NAME OF CEMETERY OR CREMATORY: Balto. Nat'l. Cem.
22d. LOCATION (City, town, or county) (State): Balto., Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: R. V. Singleton
ADDRESS: Glen Burnie, Md.

24a. REC'D BY REGISTRAR DATE: JAN 25 '60
24b. REGISTRAR'S SIGNATURE: Arthur E. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0183 CERTIFICATE OF DEATH

Reg. Dist. No. 00174

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 16 years 7mo. 27days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3V01-4
d. STREET ADDRESS: 616 Gold Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Aaron; Middle: William; Last: Nickens

4. DATE OF DEATH: Month: 1; Day: 21; Year: 19 60

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: January 14, 1917

9. AGE (In years last birthday): 43 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Luther Nickens

14. MOTHER'S MAIDEN NAME: Florence

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Hospital Records
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Purulent Peritonitis — INTERVAL BETWEEN ONSET AND DEATH
540.1
DUE TO
(b): Chronic Gastric Ulcer, Perforated
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. --------19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5/24, 1943, to 1/21, 19 60, that I last saw the deceased alive on 1/21, 19 60, and that death occurred at 6:05 P.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Hildegard Heard Reiss M.D.
ADDRESS (Street, city or town, state): Crownsville State Hospital, Md.
DATE SIGNED: 1/22/60

PHYSICIAN'S NAME (Type): Hildegard Heard Reissman, M. D.
Crownsville State Hospital, Md. 1/22/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1-26-60
22c. NAME OF CEMETERY OR CREMATORY: Old St John com
22d. LOCATION (City, town, or county) (State): Lancaster Co, Va

23. FUNERAL DIRECTOR'S SIGNATURE: George B. Watson
ADDRESS: 1348 W. Baltimore St

24a. REC'D BY REGISTRAR DATE: JAN 27 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0184 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00175

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ferndale
c. LENGTH OF STAY IN 1b: 3 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 201 Ferndale Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Same — b. COUNTY: Same
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Same
d. STREET ADDRESS: / Same
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WLADYSLAW Middle Last Wlaysdaw Olszewski
4. DATE OF DEATH: Month January Day 23rd. Year 1960

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: ?
9. AGE (In years last birthday): 90 ? yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired stevedare
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Polnnd EUrope
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 218-07-1143
17. INFORMANT: Mr. John Olszewswski (Son) Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): General Arterisoclerosis — INTERVAL BETWEEN ONSET AND DEATH: Many years.
450.0
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

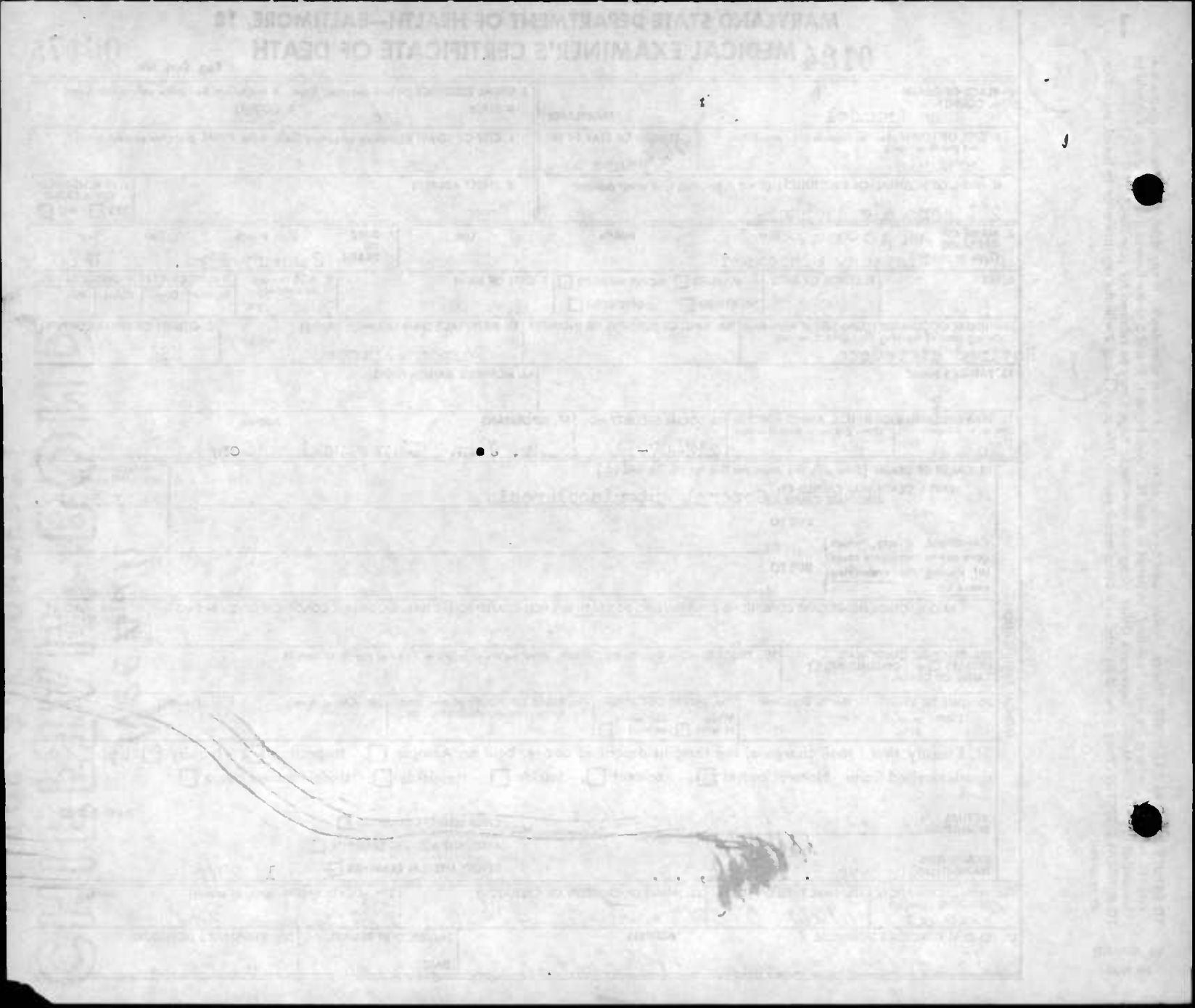
ACTUAL SIGNATURE: Gustave H Faubert M.D. — DATE SIGNED
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Gustave H. Faubert, M.D. — 1/23/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/26/60
22c. NAME OF CEMETERY OR CREMATORY: St. Stanislaus Cem.
22d. LOCATION (City, town, or county) (State): Baltimore Md

23. FUNERAL DIRECTOR'S SIGNATURE: Fred W Ozazewski — ADDRESS: 1930 Eastern Ave
24a. REC'D BY REGISTRAR: DATE JAN 27 '60
24b. REGISTRAR'S SIGNATURE: Arthur E Kruse

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00176

0134 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 154 King George St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 154 King George St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: GUSTAV RUDOLF WILHELM WILLIAM Middle: PAAR Last: PAAR.

4. DATE OF DEATH: Month: 1 Day: 30 Year: 1960

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11-25-1890

9. AGE (In years last birthday): 69 yrs.

IF UNDER 1 YEAR — Months: Days: IF UNDER 24 HRS. — Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Real Estate

10b. KIND OF BUSINESS OR INDUSTRY: Ret.

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT: Viva Head Paar — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: minutes
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month: Day: Year: 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/6, 1960, to 1/30, 1960, that I last saw the deceased alive on 1/27/60, 19, and that death occurred at 9:55 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard N Peeler M.D. — ADDRESS (Street, city or town, state): 121 Cathedral St. — DATE SIGNED: 1/30/60

PHYSICIAN'S NAME (Type): RICHARD N. PEELER — Annapolis, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: 2-1-60

22c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln

22d. LOCATION (City, town, or county) (State): Prince George Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor & Sons — ADDRESS: Annapolis Md.

24a. REC'D BY REGISTRAR — DATE: FEB 2 '60

24b. REGISTRAR'S SIGNATURE: Clarence E. Keene

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

0185 00177

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 3½ years
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 231 St. James Drive

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Same
b. COUNTY: Same
c. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): 60 Same
d. STREET ADDRESS: Same
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Lilia Middle Last Peters

4. DATE OF DEATH: Month January Day 30th. Year 19 60

5. SEX: F

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11/22/72

9. AGE (In years lost birthday): 87 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Char Woman

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frank Peters

14. MOTHER'S MAIDEN NAME: Elizabeth Catherine Nichols

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. Lawrence Busch, 231 St. James Drive, Glen Burnie, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): General Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: ?

450.0

DUE TO (b):

Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse lost. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Doy, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from January 25, 1960, to January 30, 19 60 that (I) (we) last saw the deceased alive on 1/29/60 19___, and that death occurred at 4 AM, from the causes and on the date stated above.

22a. SIGNATURE: Gustave H. Faubert M.D. M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1/30/60

22c. PHYSICIAN'S NAME (Type): Gustave H. Faubert, M.D.

22d. ADDRESS: Glen Burnie, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/2/60

23c. NAME OF CEMETERY OR CREMATORY: New Cathedral Cemetery

23d. LOCATION (City, town, or county) (State): Baltimore, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Leonard J. Ruck 5305 Harford Road #14

25a. REC'D BY REGISTRAR DATE: FEB 3 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00178

1. PLACE OF DEATH
a. COUNTY: Anne Arundel 0186 MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route 9 Box 213

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Same
b. COUNTY: Same
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Same
d. STREET ADDRESS: Same
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William Middle: Rodell Last: Pinkard

4. DATE OF DEATH: Month: January Day: 5th, Year: 1960

5. SEX: M.
6. COLOR OR RACE: C.
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9/28/59
9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months: 3 Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Pinkard
14. MOTHER'S MAIDEN NAME: Josephine Morgan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT Address: William Pinkard (Father).

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Infection of the respiratory tract. — INTERVAL BETWEEN ONSET AND DEATH

527.2

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Gustave H Faubert M.D. — CHIEF MEDICAL EXAMINER ☐ — DATE SIGNED

EXAMINER'S NAME (Type): Gustave H. Faubert, M.D. — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — 1/5/60

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 1-8-60
22c. NAME OF CEMETERY OR CREMATORY: HALLS METHODIST CHURCH YARD
22d. LOCATION (City, town, or county) (State): MARLEY NECK Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Josiah L. Brown & Son — ADDRESS: 108 W. Montgomery St.
24a. REC'D BY REGISTRAR DATE: JAN 1 1960
24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)
5M 9/55

2038192XV3

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FOR STATE HEALTH DEPT.

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099

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01522

Item 4 Film G258 3-7-60 et

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

1. PLACE OF DEATH
   a. COUNTY: Anne Arundel — 0135 — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
   c. LENGTH OF STAY IN 1b: D, ~~O~~, A,
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Howard
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hanover 13 X-2
   d. STREET ADDRESS: Hawkins Drive — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: PATRICIA — Middle: ANN — Last: QUINN

4. DATE OF DEATH: Month: January ~~February~~ — Day: 31 ~~1~~ — Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 21, 1959

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months: 7 — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Baltimore Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: BERNARD QUINN

14. MOTHER'S MAIDEN NAME: PEGGY Fuchs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: BERNARD QUINN, - SAME AS 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Massive aspiration of stomach content complicating gastro-enteritis — INTERVAL BETWEEN ONSET AND DEATH

571.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): — (c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 —

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Russell S Fisher M.D.

EXAMINER'S NAME (Type): Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

Address (Street, city, town, or county):

DATE SIGNED: 2/1/60

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 22b. DATE THEREOF: 2-3-60 — 22c. NAME OF CEMETERY OR CREMATORY: Glen Haven — 22d. LOCATION (City, town, or country) (State): Glen Burnie Md

23. FUNERAL DIRECTOR — ADDRESS: Hopping & Kirkner, Glen Burnie

24a. REC'D BY REGISTRAR DATE: FEB 4 '60 — 24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

2040334XV3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00179

0187

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relo[illegible] by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

1. PLACE OF DEATH a. COUNTY xxxBaltimorexx Anne Arundel MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY A.A.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum Heights c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum Heights
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 300 Greenwood Road	d. STREET ADDRESS 300 Greenwood Road e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
JOHN	A.	REILLY	Jan	16	1960

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White		Oct. 10, 1889	70 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired-Adjudication Officer-Veterans Admin.		Massachusetts	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John O'Reilly	Mary Ann ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes World War I	None	Mrs. Mabel F. Reilly-300 Greenwood Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH 2 yrs.

422.1

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan, 1942, to Jan 16, 1960, that I last saw the deceased alive on Jan 16, 1960, and that death occurred at 11:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Chas. L. Ball Jr. M.D. — ADDRESS (Street, city or town, state) 203 W. Maple Rd. Linthicum Md. — DATE SIGNED 1/17/60

PHYSICIAN'S NAME (Type) CHARLES L. BALL, JR.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	1/21/60	St. Patricks Cemetery	Wareham, Mass.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Wm. J. Tuckey & Sons	Balto-17, Md.	JAN 18 '60	Carlton S. Krause

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

0188 — Reg. Dist. No. 00180

1. PLACE OF DEATH
a. COUNTY: Ann Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 14 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Plaza Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: ~~131~~ Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3V01-4
d. STREET ADDRESS: 131 N. Aisquith St. Balto.2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Rosa Mae — Middle — Last Ricks
4. DATE OF DEATH: Month January — Day 22, — Year 1960
5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 12, 1909
9. AGE (In years last birthday): 50 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): ~~Unknown~~ N.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ~~Unknown~~ Willie Ricks
14. MOTHER'S MAIDEN NAME: ~~Unknown~~ Minnie Ricks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 213-09-5119
17. INFORMANT: Deceased — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Inoperable carcinoma lungs — INTERVAL BETWEEN ONSET AND DEATH: about 1 yr.
163X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 8, 1960 to Jan. 22, 19 60, that I last saw the deceased alive on Jan. 16, 19 60, and that death occurred at 4 A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James M. Pair M.D. — ADDRESS (Street, city or town, state): 400 N. Carrollton Ave. Balto.23 — DATE SIGNED: 1-22-1960

PHYSICIAN'S NAME (Type): James M. Pair, M.D. — Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal — 22b. DATE THEREOF: 1-29-60 — 22c. NAME OF CEMETERY OR CREMATORY: N. B. Mt. Calvary — 22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Beese, D. — ADDRESS: Cantn. Md.

24a. REC'D BY REGISTRAR DATE: JAN 27 60 — 24b. REGISTRAR'S SIGNATURE: Arthur L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0189

CERTIFICATE OF DEATH

00181

Reg. Dist. No. 27

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort George G Meade
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: U.S. Army Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL ond give nearest tawn): Baltimore 3V01-4
d. STREET ADDRESS: 133 S. Loudon Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SHELBY Middle A Last ROBBINS

4. DATE OF DEATH: Month January Day 17 Year 1960

5. SEX: Male

6. COLOR OR RACE: Cau

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 20 April 1880

9. AGE (In years lost birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Army

11. BIRTHPLACE (State or foreign country): TENN.

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES. (If yes, give war or dates of service): 1898-1928

16. SOCIAL SECURITY NO.: —

INFORMANT: MRS. MARY E. Robbins Address 133 S. Loudon Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 days
527.2
DUE TO (b): Chronic lung disease — 10 years
Conditions, if ony, which gave rise to immediate couse (a), stoting the underlying couse last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II af item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factary, street, office bldg., etc.)

20f. (City or tawn) (County) (State)

21. I certify that I attended the deceased from 0800 17 Jan 19___, to 60, 19___, that I last saw the deceased alive an 17 Jan, 19 60, and that death occurred at 2.40 PM, from the causes and on the date stated abave.

ADDRESS (Street, city or town, state) 17 Jan 60 DATE SIGNED

ACTUAL SIGNATURE: _____ M.D. U.S. Army Hosp Ft Geo G Meade, Md.

PHYSICIAN'S NAME (Type) STANLEY SIEGELMAN, Capt., M.C. Stanley Siegelman

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/20/60
22c. NAME OF CEMETERY OR CREMATORY: BALTO. NAT. CEM.
22d. LOCATION (City, town, or county) (State): BALTO. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: G. Truman Schwab ADDRESS: 3512 Fred. Ave.

24a. REC'D BY REGISTRAR DATE: JAN 20 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Frana

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

0190 Reg. Dist. No. 00182

1. PLACE OF DEATH
a. COUNTY: Anne Arundel County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville
c. LENGTH OF STAY IN 1b: 3 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Box 83 RTE 2 Millersville Md.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Millersville
d. STREET ADDRESS: Box 83 Rte. 2 Millersville
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WALTER Middle MAX Last RUDORF

4. DATE OF DEATH: Month Jan Day 17 Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Dec. 28 1885

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cylinder Press Man

10b. KIND OF BUSINESS OR INDUSTRY: U.S.Lithograph

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Tristian Rudorf

14. MOTHER'S MAIDEN NAME: Sylvia Semon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Annie Rudorf Address: Millersville Box 83 Rte 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertensive Cardio Vascular Dis — 443X — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs
DUE TO (b): Arterio-sclerosis
DUE TO (c):

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour o. m. p. m.; 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March, 1957 to January, 1960, that I last saw the deceased alive on January 11, 1960, and that death occurred at 12:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: C.R. MacDonald M.D. M.D. — ADDRESS (Street, city or town, state): 204 Crain Hwy. Glen Burnie — DATE SIGNED: 1-17-60

PHYSICIAN'S NAME (Type): C.R. Mac Donald M.D — Glen Burnie Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Jan 19 1960

22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Mem Park

22d. LOCATION (City, town, or county) (State): Glen Burnie Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Hopping & Kirkley Funeral Home Glen Burnie

24a. REC'D BY REGISTRAR DATE: JAN 20 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00183

0191

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 48 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wash
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 69 W. North Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Viola — Middle: Lumenta — Last: Saunders

4. DATE OF DEATH: Month: 1 — Day: 30 — Year: 1960

5. SEX: F

6. COLOR OR RACE: C

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 9/13/93

9. AGE (In years last birthday): 66 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: housekeeper?

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Dave Saunders?

14. MOTHER'S MAIDEN NAME: Emma Taylor?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none?

17. INFORMANT: Address: Medical Record

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Heart Foilure — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
450.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): General Arteriosclerosis
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 23, 1958, to 1-30, 1960, that I last saw the deceased alive on 1-30, 1960, and that death occurred at 7:55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Carl B Schleifer M.D. — ADDRESS (Street, city or town, state): CROWNSVILLE STATE HOSP — DATE SIGNED

PHYSICIAN'S NAME (Type): CARL B. SCHLEIFER M.D. — CROWNSVILLE MD. — 1-31-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb 3-1960

22c. NAME OF CEMETERY OR CREMATORY: Pine Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John R Watson Jr. — ADDRESS: Hagerstown Md.

24c. REC'D BY REGISTRAR DATE: FEB 4 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

VS A1S (4)
15M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

00184

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0192 # CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH

COUNTY ANNE ARUNDEL — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BAY RIDGE

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 RIVER DRIVE

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE MARYLAND COUNTY ANNE ARUNDEL

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BAY RIDGE

STREET ADDRESS (If rural give location) 90 RIVER DRIVE

3. NAME OF DECEASED (Type or Print) (First) ELEANOR (Middle) C. (Last) Scott

4. DATE OF DEATH (Month) JAN. (Day) 13 (Year) 1960

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
FEM.	WHITE		MAY 23, 1878	81 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	—	PENNSYLVANIA	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
WILLIAM W. CARSON	JENNIE GOULD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
—	—		MRS CHARLES KEOWN #2

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.0 IMMEDIATE CAUSE (A) Generalized Arteriosclerosis Typ. — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSE(S) DUE TO (B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	—	YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY—street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
		—

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-13, 1960, to 1-13, 1960, that I last saw the deceased alive on 1-13, 1960, and that death occurred at 3P M, from the causes and on the date stated above.

SIGNATURE Frank M Shipley M.D. **ADDRESS** (Street, city, town, state) 121 Cathedral St **DATE SIGNED** 1-13-60

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1-16-1960	ALLEGHENY MEM.	ALLEGHENY Co. PA.

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
JAN 15 '60	Arthur S. Krauss	JOHN M. TAYLOR SON ANNAPOLIS MD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 21

1952 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

0193

00165
00185

Reg. Dist. No. 27

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Anne Arundel ✓

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort George G. Meade
c. LENGTH OF STAY IN 1b:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Odenton

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: US ARMY HOSPITAL FT GEO. G. MEADE
d. STREET ADDRESS: Box 127-B
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Lloyd	L.	Shafer	January	16	19 60

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Cauc		19 February 1936	23 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Soldier	US Army	Lesage, West, Virginia	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unk	Unk

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
YES		Personnel Records Ft Geo G Meade, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): MULTIPLE INTERNAL INJURIES — INTERVAL BETWEEN ONSET AND DEATH:

825X

DUE TO (b): AUTOMOBILE ACCIDENT — 1 HR 45 MIN

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour	Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not while at work ☒	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
o. m. 0100 p. m.	Jan 16 60		Rt 170		Anne Arundel	Md

21. I certify that I attended the deceased from 16 JAN 19 60, to 16 JAN 19 60, that I last saw the deceased alive on 16 JAN 19 60, and that death occurred at 0245A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Matthew N. Harris M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED: 16 Jan 60

PHYSICIAN'S NAME (Type): MATTHEW N HARRIS, Capt., M.C. USA Hospital Ft Geo G Meade, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
BURIAL	1-21-60	Arlington National	Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Wm. Cook, Inc., 1217 St. Paul Street	JAN 21 '60	Arthur L. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,13,14 FilmG255 2-8-60 et

0194

CERTIFICATE OF DEATH

Reg. Dist. No. 00186

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Ft Geo. G. Meade - US Army Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Ft. Geo. G. Meade, Md.
d. STREET ADDRESS: 7234-D Johnson St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

050

3. NAME OF DECEASED (Type or print): First: Richard — Middle: B. — Last: Shepard

4. DATE OF DEATH: Month: January — Day: 21 — Year: 19 60

5. SEX: Male

6. COLOR OR RACE: Cauc.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 21, 1897

9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Mississippi

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jack Shepard

14. MOTHER'S MAIDEN NAME: Nannie Kilgore

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: (Son) Sgt William Shepard Qtrs 7234-D FGGM,MD — Address

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertension — INTERVAL BETWEEN ONSET AND DEATH: 4 years
DUE TO
420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerotic heart disease — 4 years
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from —, 19____, to —, 19___, that I last saw the deceased alive on —, 19____, and that death occurred at 607 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Henry N. Claman M.D. — ADDRESS (Street, city or town, state): Was dead on arrival at hospital — DATE SIGNED

PHYSICIAN'S NAME (Type): HENRY N. CLAMAN, CAPT MC — US ARMY HOSPITAL, FORT G. G. MEADE, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1-23-60

22c. NAME OF CEMETERY OR CREMATORY: Bassett Cemetery

22d. LOCATION (City, town, or county) (State): Bassett West Memphis Arkansas

23. FUNERAL DIRECTOR'S SIGNATURE & ADDRESS: John M. Weber & Sons Inc. 401 S. Chester St.

24a. REC'D BY REGISTRAR DATE: JAN 25 '60

24b. REGISTRAR'S SIGNATURE: Collins & Evans

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0195 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00187

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cape St. Clair
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Swan Drive

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: North Carolina — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Camp LeJeune 70 X-3
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RAYMOND Middle VINCENT Last SHERMAN

4. DATE OF DEATH: Month January Day 19 Year 1960

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 1, 1935
9. AGE (In years last birthday): 24 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. Marine
10b. KIND OF BUSINESS OR INDUSTRY: Marine Corp.
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William G. Sherman, Sr.
14. MOTHER'S MAIDEN NAME: Rita Alfinito

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): 1952-1960
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Rita Sherman, Mother Address: 4120 Park Hgts. Baltimore, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Poisoning by Carbon Monoxide — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 973.1

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Connected hose to exhaust pipe of his car.
20c. TIME OF INJURY: Hour ~~AM~~ PM Month, Day, Year: 1-18 1960
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): car in Yard
20f. (City or town) Cape St. Clair, A.A. (County) (State) Md

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Gustave H Faubert M.D. — DATE SIGNED

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Gustave H. Faubert, M.D. — 1/1/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/22/60
22c. NAME OF CEMETERY OR CREMATORY: Cathedral Cemetery.
22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: C. Vernon Lemmon — ADDRESS: 4611 Park Heights, Balto. Md.
24a. REC'D BY REGISTRAR DATE: JAN 21 '60
24b. REGISTRAR'S SIGNATURE:

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00188

1. PLACE OF DEATH
a. COUNTY: Anne Arundel 019S — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Odenton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Box 438X, Route 1

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): X Odenton
d. STREET ADDRESS: Box 438X, Route 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First KATHLEEN — Middle ANNE — Last SINGLETON
4. DATE OF DEATH: Month January — Day 10, — Year 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12/9/59
9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months 1 — Days 1 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Fort Meade, Hospital, M.D.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Roscoe E. Singleton
14. MOTHER'S MAIDEN NAME: Dona M. Hood

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Mr. and Mrs. R. E. Singleton (parents)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Interstitial pneumonitis — INTERVAL BETWEEN ONSET AND DEATH:
492X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Russell S Fisher M.D.
CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type): Russell S. Fisher, M.D.
Address (Street, city, town, or county)
DATE SIGNED: 1/11/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1-11-1960
22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Cemetery
22d. LOCATION (City, town, or country) (State): Glen Burnie - md.

23. FUNERAL DIRECTOR — ADDRESS: Robert P. Ware - Glen Burnie
24a. REC'D BY REGISTRAR — DATE: JAN 13 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Hinkle

2050191XV3

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any ... is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for his files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME 5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 FilmG254 1-22-60 et

00189

CERTIFICATE OF DEATH

Reg. Dist. No. 0197

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 22 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 505 Oakland Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Clara; Middle: Johnson; Last: Smith

4. DATE OF DEATH: Month: 1; Day: 18; Year: 1960

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 3, 1889/ 1890

9. AGE (In years last birthday): 70 69 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook - Maid

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Martha Lane

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-16-5333

INFORMANT: Chas. E. Smith — Address: 505 Oakland ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Uremia — INTERVAL BETWEEN ONSET AND DEATH: Since Admissio
DUE TO
443X
Conditions, if ony, which gove rise to immediate couse (o), stoting the underlying couse last.
(b): Arteriosclerotic Hypertensive Cardiovascular Disease
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.): ----------

20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. 19 ----------

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) ----------

20f. (City or town) (County) (State)

21. I **certify** thot I attended the deceosed from 12/26, 19 59, to 1/18, 19 60, thot I lost sow the deceosed olive on 1/18, 19 60, ond thot deoth occurred at 1:60P.M, from the couses ond on the dote stated above.

ACTUAL SIGNATURE: Hildegard Heard Reissman M.D. — ADDRESS (Street, city or town, state): Crownsville State Hospital, Md. — DATE SIGNED: 1/18/60

PHYSICIAN'S NAME (Type): Hildegard Heard Reissman, M. D. — Crownsville State Hospital, Md. — 1/18/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1-21-1960
22c. NAME OF CEMETERY OR CREMATORY: Brewer Hill
22d. LOCATION (City, town, or county) (State): Annapolis Md

23. FUNERAL DIRECTOR'S SIGNATURE: William B. Reese — ADDRESS: Annap. Md.

24a. REC'D BY REGISTRAR — DATE: JAN 20 '60

24b. REGISTRAR'S SIGNATURE: Carlton S. Krauss

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 8,9 FilmG254 1-18-60 et

Reg. Dist. No. 00190

1. PLACE OF DEATH? a. COUNTY A. A. Co. 0136 MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY A A Co

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis RURAL

c. LENGTH OF STAY IN 1b D.O.A.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Anne Arundel General

e. STREET ADDRESS 15 Normandy Drive

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Walter Middle H. Last Smith Jr.

4. DATE OF DEATH Month 1 Day 3 Year 1960

5. SEX M

6. COLOR OR RACE W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 1-15-27 1932

9. AGE (In years last birthday) 27 yrs.

IF UNDER 1 YEAR Months Days

IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Marine Mechanic

10b. KIND OF BUSINESS OR INDUSTRY Stickle Marine

11. BIRTHPLACE (State or foreign country) Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Walter H. Smith Sr.

14. MOTHER'S MAIDEN NAME Evelyn A. Kennedy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) Korean

16. SOCIAL SECURITY NO. 215-28-6101

17. INFORMANT Address Mrs. Dorothy L. Smith Same As #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Head Injury — INTERVAL BETWEEN ONSET AND DEATH Instant

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

823x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto accident - ran into pole

20c. TIME OF INJURY Hour a. m. Month, Day, Year 1-3 1960

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. 2

20f. (City or town) AA Co (County) (State) MD

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE [signature] M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED 1/5/60

EXAMINER'S NAME (Type) E. Linhardt

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 7 Jan. '60

22c. NAME OF CEMETERY OR CREMATORY Glen Haven

22d. LOCATION (City, town, or county) Glen Burnie (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE P. Y. Singleton

ADDRESS Glen Burnie, Md

24a. REC'D BY REGISTRAR DATE JAN 7 '60

24b. REGISTRAR'S SIGNATURE [signature]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00191

1. PLACE OF DEATH
a. COUNTY A.A.Co 0137 MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis Hospital
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD b. COUNTY AACo
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mayo
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First Wm. Middle Everett Last Smith
4. DATE OF DEATH Month 1 Day 5 Year 1960
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 12/8/33
9. AGE (In years last birthday) 26 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boat Carpenter
10b. KIND OF BUSINESS OR INDUSTRY John Trumphy
11. BIRTHPLACE (State or foreign country) Baltimore) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Walter H. Smith Sr.
14. MOTHER'S MAIDEN NAME Evelyn A. Kennedy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes. (If yes, give war or dates of service) Korean
16. SOCIAL SECURITY NO. 213-30-6128
17. INFORMANT Address Mrs. Arden J. Smith Same As #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Head Injury
823x
DUE TO (b)
Conditions, if any, which gave rise to immediate couse (a), stoting the underlying couse last. DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH 3 + hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto, Accident - ran into pole
20c. TIME OF INJURY Hour ~~p.~~ a. m. Month, Day, Year 1.3 1960
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route # 2
20f. (City or town) (County) AACo. (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE [signature] M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) E. Linhardt
DEPUTY MEDICAL EXAMINER ☑
DATE SIGNED 1.3.60.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 7 Jan. '60
22c. NAME OF CEMETERY OR CREMATORY Glen Haven
22d. LOCATION (City, town, or county) (State) Glen Burnie) Md.

23. FUNERAL DIRECTOR'S SIGNATURE R.P. Singleton ADDRESS Glen Burnie, Md.
24a. REC'D BY REGISTRAR DATE JAN 7 '60
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

0198 — Reg. Dist. No. 00192

1. PLACE OF DEATH
a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mayo
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Holly Hill Harbor

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md
b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mayo
d. STREET ADDRESS: Holly Hill Harbor
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Raleigh — Last: Swift Sr.

4. DATE OF DEATH: Month: 1 — Day: 10 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 27th 1877

9. AGE (In years last birthday): 82 yrs.

IF UNDER 1 YEAR / IF UNDER 24 HRS.: Months | Days | Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waterman

10b. KIND OF BUSINESS OR INDUSTRY: Crabs & Oysters

11. BIRTHPLACE (State or foreign country): Mayo Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Edward Swift

14. MOTHER'S MAIDEN NAME: Harriet Ann Lee

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Edward Swift — Address: 38 Annapolis St Annapolis Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): Arteriosclerotic Heart Disease — 1 yr
DUE TO (c):

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 52, to 1-10-, 1960, that I last saw the deceased alive on 1-9-60, and that death occurred at 9:15 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James R. Martin M.D. — DATE SIGNED: 1-11-60

PHYSICIAN'S NAME (Type): JAMES R. MARTIN — ADDRESS (Street, city or town, state): 6 SHAW ST. ANNAPOLIS, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1-13-60

22c. NAME OF CEMETERY OR CREMATORY: Mayo Memorial Cem

22d. LOCATION (City, town, or county) (State): Mayo Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons — ADDRESS: Annapolis Md

24a. REC'D BY REGISTRAR — DATE: JAN 14 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0199 CERTIFICATE OF DEATH

Reg. Dist. No. 00193

1. PLACE OF DEATH
a. COUNTY: a a — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riva
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sylvan Shores

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md. — b. COUNTY: a a
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): × Riva
d. STREET ADDRESS: Sylvan Shores
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Bettie — Middle M. — Last Salman

4. DATE OF DEATH: Month 1 — Day 28 — Year 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feby 21st 1909

9. AGE (In years last birthday): 50 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months — Days — Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Va.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: James H. Montague

14. MOTHER'S MAIDEN NAME: Ibra Haggarty

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT: John J. Salmon — Address: (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic carcinoma of left breast — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.
170 X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1955, 19__, to Jan 28, 1960, that I last saw the deceased alive on Jan 24, 1960, and that death occurred at 4:40 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Glen L Hedemann M.D. — ADDRESS (Street, city or town, state): 121 Catherdale — DATE SIGNED: 1/29/60

PHYSICIAN'S NAME (Type): Amaydis Wel

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 1-30-60 — 22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Cemt — 22d. LOCATION (City, town, or county) (State): Glen Burnie Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons — ADDRESS: Annapolis Md

24a. REC'D BY REGISTRAR DATE: FEB 2 '60 — 24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0200 **CERTIFICATE OF DEATH** 00194

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Anne Arundel · MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena
c. LENGTH OF STAY IN 1b 14 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 142 Pasadena Md

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X3805 Rokeby Rd. Zone 29
d. STREET ADDRESS Balto Md
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First: Florence Middle: Elizabeth Last: Taylor

4. DATE OF DEATH Month: 1 Day: 23 Year: 1960

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH Dec. 1877

9. AGE (In years last birthday) 82 yrs.

IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Balto. Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME [redacted] Ebbensworth

14. MOTHER'S MAIDEN NAME Janie (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. None

17. INFORMANT Mrs. Virginia Newcomer Daughter Address 3805 Rokeby Rd. Balto. #29, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
422.1
DUE TO
(b) Arterio-sclerotic C.V. Disease
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1959, 19____ to 1960, 19____, that I last saw the deceased alive on 1-21-60, 19____, and that death occurred at 4:35 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE Robert R Hahn M.D. ADDRESS (Street, city or town, state) Severna Park Md DATE SIGNED 1-23-60

PHYSICIAN'S NAME (Type) Robert R. Hahn

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 27 Jan '60

22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.

22d. LOCATION (City, town, or county) Glen Burnie (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE R. V. Singleton ADDRESS Glen Burnie, Md.

24a. REC'D BY REGISTRAR DATE JAN 26 '60

24b. REGISTRAR'S SIGNATURE Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0201 CERTIFICATE OF DEATH

Reg. Dist. No. 00195

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 7 years 9mo. 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D. C.? 18X-2
d. STREET ADDRESS: Unknown
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William; Middle: Alexander; Last: Thompson

4. DATE OF DEATH: Month: 1; Day: 25; Year: 1960

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3/5/1896

9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Thompson

14. MOTHER'S MAIDEN NAME: Martha Eyglen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes World War I

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Hospital Records
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion
420.1
DUE TO
(b): Arteriosclerotic Hypertensive Cardiovascular Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4/22 1952 to 1/25 1960 that I lost saw the deceased alive on 1/25 1960 and that death occurred at 6:50P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Hildegard Heard Reissman M.D.
ADDRESS (Street, city or town, state): Crownsville State Hospital, Md.
DATE SIGNED: 1/26/60

PHYSICIAN'S NAME (Type): Hildegard Heard Reissman, M. D.
Crownsville State Hospital, Md. 1/26/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1-30-60
22c. NAME OF CEMETERY OR CREMATORY: St Francis Xavier
22d. LOCATION (City, town, or county) (State): Compton Md.

23. FUNERAL DIRECTOR'S SIGNATURE: M. Clarke Mattingley
ADDRESS: Leonardtown, Md.

24a. REC'D BY REGISTRAR DATE: FEB 1 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

0262 — Reg. Dist. No. 00196

1. PLACE OF DEATH
a. COUNTY: Anne Arundel Co — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenburnie
c. LENGTH OF STAY IN 1b: 74 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 511 Hamlen Rd.

2. USUAL RESIDENCE (Where deceased lived—If institution: Residence before admission)
a. STATE: Anne Arundel Co
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X - Glen Burnie
d. STREET ADDRESS: 511 Hamlen
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Milton — Middle: J. — Last: Turner

4. DATE OF DEATH: Month: Jan — Day: 3 — Year: 1960

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 19 Feb. 1872

9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fireman (Retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Anne Arundel Co Md

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: James W. Turner

14. MOTHER'S MAIDEN NAME: Catherine C. (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

INFORMANT: Mr. Walter Travers — Address: 29 westgate Rd - Balto. 29

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
332x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Lobar Pneumonia — 3 days
DUE TO
(c): Cerebral Infarct — 1 week

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
Chronic Insufficiency

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month — Day — Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 1 - 59 to Jan 3 - 1960, that I last saw the deceased alive on Jan 2 - 1960, and that death occurred at 8 P. M. from the causes and an the date stated above.

ACTUAL SIGNATURE, M.D.: Joseph Lipsker
ADDRESS (Street, city or town, state): Glenburnie Md
DATE SIGNED: 1/3/60
PHYSICIAN'S NAME (Type): JOSEPH LIPSKER

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6 January 1960
22c. NAME OF CEMETERY OR CREMATORY: St. Stephens Ch. Cem.
22d. LOCATION (City, town, or county) (State): Millersville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: P. F. Singleton
ADDRESS: Glen Burnie Md.

24a. REC'D BY REGISTRAR DATE: JAN 7 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kinna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00197

0138 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 909 WELLS AVE

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: A. A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 ANNAPOLIS
d. STREET ADDRESS: 1909 WELLS AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EDWARD — Middle T. — Last TYDINGS

4. DATE OF DEATH: Month 1 — Day 21 — Year 1960

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 5-18-1884

9. AGE (In years last birthday): 75 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): STREET DEPT.

10b. KIND OF BUSINESS OR INDUSTRY: City Gov't.

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: GEORGE R. TYDINGS

14. MOTHER'S MAIDEN NAME: MARY R. KING

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 215-24-9803

17. INFORMANT: MRS. JONES — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CEREBRAL THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 7 DAYS

332x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): CEREBRAL ARTERIOSCLEROSIS — 5 YEARS

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): MALNUTRITION

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12-15, 1959, to 1-21, 1960, that I last saw the deceased alive on 1-21, 1960, and that death occurred at 4 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward A Beck M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED 1/22/60

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 1-25-60

22c. NAME OF CEMETERY OR CREMATORY: CEDAR BLUFF

22d. LOCATION (City, town, or county) (State): ANNAPOLIS MD.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor & Sons — ADDRESS: Annapolis, Md

24a. REC'D BY REGISTRAR — DATE: JAN 25 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00198

Reg. Dist. No. 0139

1. PLACE OF DEATH
a. COUNTY: A A Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A. Anne Arundel Gen.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Balto.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 03X-2
d. STREET ADDRESS: 4130 Wilkens Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Gertrude — Middle L. — Last WALMER.

4. DATE OF DEATH: Month 1 — Day 27 — Year 1960

5. SEX: F. — 6. COLOR OR RACE: W. — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐ — 8. DATE OF BIRTH: Oct. 20, 1884 — 9. AGE (In years last birthday): 75 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Springfield, Illinois
12. CITIZEN OF WHAT COUNTRY? U. S.A.

13. FATHER'S NAME: Theodore Hanft
14. MOTHER'S MAIDEN NAME: Louisa Bender

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Dorothy Frantz — Address: 4130 Wilkens Ave. #29

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac Disease — INTERVAL BETWEEN ONSET AND DEATH: Hasten
434.4
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour, Month, Day, Year — o. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.
EXAMINER'S NAME (Type): E. Linhardt.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 1.27.60.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1'30'60
22c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery
22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Howard H. Hubbard 4107 Wilkens Ave.
24a. REC'D BY REGISTRAR DATE: JAN 29 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0203 **CERTIFICATE OF DEATH** Reg. Dist. No. 00199

1. PLACE OF DEATH
a. COUNTY ~~Cro~~ Queen Anne's MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY SOMERSET ✓

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CROWNSVILLE

c. LENGTH OF STAY IN 1b 3/22/49

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD 1939-2

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CROWNSVILLE STATE HOSPITAL

d. STREET ADDRESS CRISFIELD

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First WILLIAM Middle S. Last WATERS

4. DATE OF DEATH Month 1 Day 16 Year 1960

5. SEX M

6. COLOR OR RACE C

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH UNKNOWN TO US

9. AGE (In years last birthday) 50 + yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) NOT LISTED

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME WILLIAM T. WATERS

14. MOTHER'S MAIDEN NAME NOT LISTED

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. NONE

17. INFORMANT Address HOSPITAL RECORDS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) KACHEXIA — INTERVAL BETWEEN ONSET AND DEATH 2 yrs.

026X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) GENERAL PARESIS — Known since his admission in 1949

DUE TO (c) CHRONIC BRAIN SYNDROME ASSOCIATED WITH C.N. SYPHILIS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/22 19 49, to 1/16 19 60, that I last saw the deceased alive on 1/16/60 19 , and that death occurred at 2:15 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE L. Benedict M.D. ADDRESS (Street, city or town, state) CROWNSVILLE STATE HOSPITAL DATE SIGNED

PHYSICIAN'S NAME (Type) L. BENEDICT M.D. CROWNSVILLE, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

22b. DATE THEREOF JAN. 19, 1960

22c. NAME OF CEMETERY OR CREMATORY LAWSONIA CEMETERY

22d. LOCATION (City, town, or county) CRISFIELD (State) MD.

23. FUNERAL DIRECTOR'S SIGNATURE BRADSHAW & SONS ADDRESS CRISFIELD, MD.

24a. REC'D BY REGISTRAR DATE JAN 20 '60

24b. REGISTRAR'S SIGNATURE Emma L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00200 27

0204

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort George G Meade
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Army Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Fort George G Meade
d. STREET ADDRESS: Quarters # 7020-A
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First KATHI Middle DAWN Last WATKINS

4. DATE OF DEATH: Month January Day 8 Year 19 60

5. SEX: Female

6. COLOR OR RACE: Cau

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10 October 58

9. AGE (In years last birthday): 1 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Fred Warren Watkins

14. MOTHER'S MAIDEN NAME: Anna Dawn Wallace

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

INFORMANT: (F) Fred W Watkins Address: Ft Geo G Meade, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory failure — INTERVAL BETWEEN ONSET AND DEATH: Unknown

331X

DUE TO
Conditions, if ony, which gave rise to immediate couse (a), stoting the underlying cause lost.
(b) Central Nervous system, hemorrhage — Approx 32 hrs

DUE TO
(c) Febrile convulsion — Approx 32 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Doy, Year 19

20d. INJURY OCCURRED While at work ☐ Nat while at work ☐

20e. PLACE OF INJURY (Home, farm, factary, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7 Jan, 1960, to 8 Jan, 1960, that I last saw the deceased alive on 8 Jan, 1960, and that death occurred at 10:55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Roger C Moyer Capt MC M.D.
ADDRESS (Street, city or town, state): USA Hospital Ft Geo G Meade. Md
DATE SIGNED: 8 Jan 60

PHYSICIAN'S NAME (Type): ROGER C MOYER, Capt., ,M.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 1-13-60
22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery
22d. LOCATION (City, town, or county) (State): Arlington, Va

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Wm. Cook, Inc., 1217 St. Paul Street

24a. REC'D BY REGISTRAR DATE: JAN 12 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1c Film G255 1-27-60 et 00201

0205

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
1SM 9/55

1. PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND	**2. USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland — b. COUNTY: Baltimore City
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville — c. LENGTH OF STAY IN 1b: 1 Y. 29 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3V01-4
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Crownsville State Hospital	d. STREET ADDRESS: 616 Bradley Street — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Nathan		White	1	11	19 60

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	Negro		1/31/1890	69 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	----------	Unknown	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Ida Pollard White

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
Unknown	186-10-9855	Hospital Records

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 7-10 days

286.5

DUE TO (b) Malnutrition & Dehydration, Cachexia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cerebral Arteriosclerosis — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
- - - - - - - -	

20c. TIME OF INJURY Hour a. m. / p. m. — Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
- - -		-	- - - - - -

21. **I certify** that I attended the deceased from 12/12, 1958, to 1/11, 1960, that I last saw the deceased alive on 1/11, 1960, and that death occurred at 7:55 P.M, from the causes and on the date stated above.

	ADDRESS (Street, city or town, state)	DATE SIGNED
ACTUAL SIGNATURE: Hildegard Heard Reiss M.D.	Crownsville State Hospital, Md.	1/12/60
PHYSICIAN'S NAME (Type): Hildegard Heard Reissman, M. D.	Crownsville State Hospital, Md.	1/12/60

22a. (BURIAL) CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
	1-15-59	Mt. Auburn	Baltimore Md.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Halstead Branch	91 & 10 Pulaski Hwy Essex Md	JAN 14 '60	Arthur L. Kraus

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0206 CERTIFICATE OF DEATH

Reg. Dist. No. 00202

1. PLACE OF DEATH
a. COUNTY: A.A. Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bristol
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: A.A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x Bristol, Md
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Gus — Middle: Edward — Last: Wilkerson

4. DATE OF DEATH: Month: 1 — Day: 30 — Year: 1960

5. SEX: M.

6. COLOR OR RACE: C

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 10,

9. AGE (In years last birthday): 49 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Wilkerson

14. MOTHER'S MAIDEN NAME: Priscella Wilkerson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Marion Wilkerson

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH:
420.1
DUE TO: Coronary artery disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a. m. / p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 29, 19 54, to Jan 29, 19 60, that I last saw the deceased alive on Not at all, 19____, and that death occurred at 8 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Emil H. Wilson, M.D. — ADDRESS (Street, city or town, state): Lothian, Md. — DATE SIGNED: 1-30-60

acting Coroner.

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 2-2-60

22c. NAME OF CEMETERY OR CREMATORY: Carters

22d. LOCATION (City, town, or county) (State): A.A. Co. Md

23. FUNERAL DIRECTOR'S SIGNATURE: P. E. Sowell — ADDRESS: Prince Frederick

24a. REC'D BY REGISTRAR — DATE: FEB 4 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0140 **CERTIFICATE OF DEATH** Reg. Dist. No. 00203

1. **PLACE OF DEATH**
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Woodland Beach
d. STREET ADDRESS: Edgewater
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First JOSEPH Middle P Last WILKINSON

4. **DATE OF DEATH**: Month January Day 6 Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 9, 1914

9. AGE (In years last birthday): 45 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Frezer box (const)

11. BIRTHPLACE (State or foreign country): Prince Geo. Co., Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Philmore Wilkinson

14. MOTHER'S MAIDEN NAME: Mary Stamp

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 220 07 5005

INFORMANT Address: Mrs Jeannette A. Wilkinson- Wife- same as # 2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 3/4 hr
DUE TO
(b): Coronary artery disease
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from January 6, 1960, to January 6, 1960, that I last saw the deceased alive on Jan 6, 1960, and that death occurred at 4:35 P.M., from the causes and on the date stated above.

Dead on arrival at hospital in ambulance

ACTUAL SIGNATURE: S Borssuck M.D. — ADDRESS (Street, city or town, state): Annapolis, Maryland — DATE SIGNED: 1/8/60

PHYSICIAN'S NAME (Type): S. Borssuck

Amended - Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1-9-60

22c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery

22d. LOCATION (City, town, or county) (State): Annapolis, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Hopping Funeral Home — ADDRESS: Annapolis, Maryland

24a. REC'D BY REGISTRAR DATE: JAN 11 '60

24b. REGISTRAR'S SIGNATURE: Cullen S. Kunes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00204

CERTIFICATE OF DEATH

0207 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY A. A. County MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Skidmore
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY A. A. County
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Skidmore
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Hattie Middle: Williams Last:
4. DATE OF DEATH Month: 1 Day: 5 Year: 1960

5. SEX: Female
6. COLOR OR RACE: Col.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 6-12-1879
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or Unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
INFORMANT: Hilda Williams Address: Skidmore Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 day
420.1
DUE TO (b): Hypertensive & Arteriosclerotic Cardiovasc. disease — 5 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cerebrovascular accident
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 27, 1951, to Jan 5, 1960, that I last saw the deceased alive on Jan 5, 1960, and that death occurred at 11:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Faye W Allen M.D. ADDRESS (Street, city or town, state): 62 Cathedral St DATE SIGNED: 1/7/60
PHYSICIAN'S NAME (Type): Faye W. Allen Annap, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1-10-1960
22c. NAME OF CEMETERY OR CREMATORY: Broadneck
22d. LOCATION (City, town, or county) (State): Skidmore Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Reese ADDRESS: Annap. Md.
24a. REC'D BY REGISTRAR DATE: JAN 13 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0208 **CERTIFICATE OF DEATH** 00205

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville
c. LENGTH OF STAY IN 1b 1mo. 18 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4
d. STREET ADDRESS 2628 Harlem Av.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Walter Middle Willoughby Last
4. DATE OF DEATH Month 1 Day 13 Year 19 60

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Negro		May 2, 1898	61 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Shipyard Worker		North Carolinia	U.S.A.

13. FATHER'S NAME Jordan Willoughby
14. MOTHER'S MAIDEN NAME Hattie Stevenson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	INFORMANT	Address
No	None	216-01-6276	Hospital Records	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH

442 X

DUE TO (b) Arteriosclerotic Cardiovascular Renal Dis.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) Old Cardiovascular Accident

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hypostatic Pneumonia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from 11/25, 19 59 to 1/13/, 19 60, that I last saw the deceased alive on 1/13, 19 60, and that death occurred at 10.00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Lionel McHenry Mapp M.D. ADDRESS (Street, city or town, state) Crownsville State Hosp, Md DATE SIGNED 1/14/60

PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M.D. Crownsville State Hosp, Md 1/14/60

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 1/17/60 22c. NAME OF CEMETERY OR CREMATORY Sutton Cem. 22d. LOCATION (City, town, or county) (State) Linston N. C.

23. FUNERAL DIRECTOR'S SIGNATURE Charles A. Cooper ADDRESS 512 Carrington Av.

24a. REC'D BY REGISTRAR DATE JAN 22 '60 24b. REGISTRAR'S SIGNATURE Curtis L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SB

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00206

CERTIFICATE OF DEATH

Reg. Dist. No. 0141

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b: 1 Yr.
d. NAME OF HOSPITAL OR INSTITUTION: 6 Dogwood Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 6 Dogwood Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LIDA Middle MYRTLE Last WILSON

4. DATE OF DEATH: Month January Day 10 Year 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec. 21, 1875
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Dunbar, Pa
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Aaron R. Dearth
14. MOTHER'S MAIDEN NAME: Eliza J. Woodward

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: Harriet Dearth Wilson, Address 6 Dogwood Rd. Annapolis, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 3 minutes
420.1
DUE TO
(b): Coronary artery insufficiency — 5 days
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April, 1958, to Jan, 1960, that I last saw the deceased alive on Jan 10, 1960, and that death occurred at 3:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: John L Hedeman M.D.
ADDRESS (Street, city or town, state): 121 Cathedral
DATE SIGNED: 1/10/60
PHYSICIAN'S NAME (Type): John L. Hedeman MD
Annapolis, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal-Burial
22b. DATE THEREOF: Jan. 11, 1960
22c. NAME OF CEMETERY OR CREMATORY: Highland Cemetery
22d. LOCATION (City, town, or county) (State): California, Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: HOPPING FUNERAL HOME
ADDRESS: Annapolis, Maryland
24a. REC'D BY REGISTRAR DATE: JAN 13 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0209 **CERTIFICATE OF DEATH** 00207

Reg. Dist. No. 27

1. **PLACE OF DEATH**
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ft Geo G Meade
c. LENGTH OF STAY IN 1b: 26 hrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: USA Hospital

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3V01-4
d. STREET ADDRESS: 1644 Warick Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First [illegible] WARREN Middle G. Last WOMACK HR

4. **DATE OF DEATH**: Month January Day 23 Year 19 60

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: January 22, '60

9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours 25 Min. 45

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Warren G Womack

14. MOTHER'S MAIDEN NAME: Jannie Murphy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

INFORMANT: Mother (as above) Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 25 hrs
DUE TO (b): — 45 min.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): —

776X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from 23 Jan, 19 60, to —, 19 —, [illegible] and that death occurred at 2:55 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Matthew N. Harris M.D.

ADDRESS (Street, city or town, state): USA HOSP FT GEO G MEADE, MD

DATE SIGNED: 23 Jan 60

PHYSICIAN'S NAME (Type): MATTHEW N HARRIS, Capt., M.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: 25 Jan '60

22c. NAME OF CEMETERY OR CREMATORY: Laboratory, U.S. Army Hospital, Fort Geo G. Meade, Md

22d. LOCATION (City, town, or county) (State)

23. FUNERAL DIRECTOR'S SIGNATURE: Betty M. Ellis Cpt MSC

ADDRESS: BETTY M. ELLIS, MSC U.S. Army Hosp. Ft Geo G Meade

24a. REC'D BY REGISTRAR: JAN 27 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

205019 IXVO

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0218 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00208 Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
c. LENGTH OF STAY IN 1b: One month
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 151 Riviera Drive (RIVIERA)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Same — b. COUNTY: Same
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Same
d. STREET ADDRESS: Same
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Michael — Middle: Daniel — Last: Zaucha

4. DATE OF DEATH: Month: January — Day: the 5th. — Year: 19 60

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 10/25/59

9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months: 2 — Days: 11
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Carl Edward Zaucha

14. MOTHER'S MAIDEN NAME: Marylin Sue W ood

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT Address: Mr. C.E.Zaucha (father).

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Respiratory tract infection — INTERVAL BETWEEN ONSET AND DEATH: ?
527.2
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Gustave H Faubert M.D. — DATE SIGNED

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Gsutave H. Faubert, M.D. — 1/5/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1-7-60
22c. NAME OF CEMETERY OR CREMATORY: GLEN HAVEN
22d. LOCATION (City, town, or county) (State): A.A.CO., MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Roger Gross — ADDRESS: 4001 RITCHIE HGWY.

24a. REC'D BY REGISTRAR DATE: JAN 11 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

20402 181XV5